Calendar No. 192

107TH CONGRESS, 1st Session | SENATE | REPORT 107–83

HEALTH CARE SAFETY NET AMENDMENTS OF 2001

OCTOBER 11, 2001.—Ordered to be printed

Mr. KENNEDY, from the Committee on Health, Education, Labor, and Pensions, submitted the following

REPORT

together with

ADDITIONAL VIEWS

[To accompany S. 1533]

The Committee on Health, Education, Labor, and Pensions, to which was referred the bill (S. 1533) to amend the Public Health Service Act to reauthorize and strengthen the health centers program and the National Health Service Corps, and to establish the Healthy Communities Access Program, which will help coordinate services for the uninsured and underinsured, and for other purposes, having considered the same, reports favorably thereon with amendments and recommends that the bill do pass.

CONTENTS

I. PURPOSE AND SUMMARY

The Health Care Safety Net Amendments of 2001 reauthorizes and strengthens the health care centers program; reauthorizes the National Health Service Corps; improves and expands rural health

programs; and establishes the Healthy Communities Access Program under the newly created Section 340 of the Public Health Service Corps. In doing so, the committee is acting to continue, improve, and increase its support for these programs, which enable safety net providers in rural and urban areas to offer health care services for millions of underserved and uninsured people. The programs included in this act are:

The Consolidated Health Center Program, authorized under Section 330 of the Public Health Service Act, supports the provision of health care services to the medically underserved—meaning those individuals living in rural or urban communities that are designated as medically underserved, or who are members of a designated medically underserved population.

The Rural Health Outreach, Network Development, and Telemedicine grant programs were added to Title III of the Public Health Service Act in the last reauthorization of the Consolidated Health Centers. These grants were designed to assist with the provision of coordinated care in rural areas.

The National Health Service Corps, authorized under Sections 331 through 338 of the Public Health Service Act, assists in the delivery of health services in health professional shortage areas by providing scholarships and loan repayments to eligible clinicians.

The Healthy Communities Access Program, authorized under newly created section 340, provides for the planning, developing, and operating expenses incurred while integrating a health care delivery system. This system will ensure the provision of a broad range of services—including primary, secondary, and tertiary services—as well as substance abuse treatment and mental health services, in hopes of filling identified or documented gaps within an integrated delivery system. Furthermore, HCAP encourages greater public-private coordination so health providers within a community can effectively maximize efforts and resources in caring for the medically underserved.

II. Background and Need for Legislation

The committee has long supported the work of safety net providers in urban and rural areas who dedicate their efforts to providing care for those individuals who would otherwise not have access to a source of regular health care. Even as data show that the number of uninsured Americans has dropped slightly to 42.6 million people, existing safety net providers continue to grapple with increasing demands for care from the uninsured and underinsured in this country.

At the same time, private market and public efforts to control costs are making it increasingly difficult for other providers to continue offering care to those without health coverage. In addition, thousands of communities across the country today continue to experience shortages of accessible, cost-effective, preventive and primary health care services especially for residents who are unable to pay for care.

In this light, it is critical that the committee act to reauthorize and improve programs that make it possible for millions of Americans to access a health care safety net. These programs are the Health Centers program, established under Section 330 of the Public Health Service Act; the National Health Service Corps program,

established under Sections 331 through 338L of the Public Health Service Act; and the rural grant programs established under Section 330A of the Public Health Service Act. Moreover, the committee has recognized the need for support of community-based efforts to integrate networks of providers to care for the uninsured, and to do so, is authorizing for the first time the new Healthy Communities Access Program.

CONSOLIDATED HEALTH CENTER PROGRAM

Introduction

In response to the large number of individuals living in medically underserved areas, as well as the growing number of special populations lacking access to preventive and primary health care services, Congress enacted the Health Center programs in the 1960s. For more than 30 years, the Health Centers program has effectively and efficiently assured access to cost-effective, high quality, preventive and primary care services, thereby improving the health status of the Nation's underserved and vulnerable populations. These programs were designed to empower communities to solve their own local access programs and to improve the health status of their underserved and vulnerable populations. They do so by building community-based primary care capacity and by offering case management, home visitation, outreach, and other enabling services to increase utilization by vulnerable populations and improve the effectiveness of the preventive and primary care they offer.

Health centers have demonstrated their ability to meet pressing local health needs while being held accountable for meeting national performance standards. The success of the Health Centers program can be directly traced to the core elements found in Section 330 of the Public Health Service Act, as established by this committee. These elements stipulate that each Federally-supported health center must:

Be located in, and serve, a community that is designated as "medically underserved," thus ensuring the proper targeting of Federal resources on areas of greatest need;

Make its services available to all residents of the community, without regard for ability to pay, and make those services affordable by discounting charges in accordance with family income for otherwise uncovered care to low-income families;

Provide comprehensive primary health care services, including preventive care (such as regular check-ups and pap smears), care for illness or injury, services that improve both the accessibility of care (such as transportation and translation services) and the effectiveness of care (such as health/nutrition education), and patient case management;

Be governed by a board of directors, a majority of whose members are active, registered patients of the health center, thus ensuring that the center is responsive to the health care needs of the community it serves.

When the committee last acted to reauthorize the Health Centers program in 1996 (Health Centers Consolidation Act of 1996, P.L. 104–299), it consolidated four separately targeted health center authorities under a single authority, while maintaining distinct re-

sources to serve vulnerable subpopulations of farm workers, homeless individuals, and residents of public housing.

1. Migrant Health Center.—The Migrant Health Center program was established by Congress in 1962 under the Migrant Health Act, Public Law 87–692, and reauthorized in 1975 by Public Law 94–63. Migrant Health Centers were created to provide a broad array of medical and support services to farm workers and their families. In addition to primary and preventive health care, many of these centers provide transportation, outreach, dental, pharmacy, and environmental health services. In 1999, a network of 125 migrant health centers provided services to approximately 600,000 migrant and seasonal farm workers and their families in more than 400 delivery sites.

2. Community Health Centers.—Community Health Centers were first funded by Congress in the mid-1960s as neighborhood health centers. By the early 1970s, approximately 100 neighborhood health centers had been established under the Economic Opportunity Act. These centers were designed to provide accessible, personal health services to low-income families. Community and consumer participation in the organization and ongoing governance of the centers remain central elements of the program. Each center is required to have a governing board, a majority of the members of which are users of the center's services.

With the phase-out of the Office of Economic Opportunity in the early 1970s, the centers supported under this authority were transferred to the Public Health Service Act. While services were directed to the poor and near poor, the centers also provided access to a broader population who could pay all or part of the cost of their health care. The Community Health Center program, as authorized under Section 330 of the Public Health Service Act, was established in 1975 by Public Law 94–63.

Over its nearly 30–year history, the Community Health Center program developed into a highly successful, cost-effective, and efficient health program providing services to medically underserved populations living in urban and rural underserved communities. The program currently serves more than 8.4 million medically underserved people in more than 2,569 service delivery sites.

3. Health Care for the Homeless.—Established under the Stewart B. McKinney Homeless Assistance Act of 1987 (P.L. 100–77), the Health Care for the Homeless program was developed by Congress to provide comprehensive, high quality, case-managed, preventive and primary health care services, including substance abuse services and mental health referrals, for homeless individuals at locations accessible to them. In 1992, Title VI of the Stewart B. McKinney Homeless Assistance Act was amended to include section 340(s), which authorizes additional Federal funding to provide outreach and primary health services for homeless children.

The Health Care for the Homeless program played a pivotal role in stimulating local collaboration and coordination of health and social services. A total of 135 organizations, including community health centers, public health departments, and other community-based health service providers, currently provide care through 1,159 urban and rural delivery sites to approximately 600,000 sick and untreated homeless people annually.

4. Health Services for Residents of Public Housing.—The Health Services for Residents of Public Housing program was established by Congress under the Disadvantaged Minority Health Improvement Act of 1990. This legislation focused on the disparity in health status of minority populations and placed emphasis on the development of delivery models that are comprehensive and address the special health problems which affect families—especially targeting pregnant women and children. Services are provided at public housing complexes or at sites either adjacent to or immediately accessible to these complexes.

In 1995, 22 organizations received funding under the section 340A authority. These centers provide comprehensive, high quality, case-managed, family based preventive and primary health care services to approximately 25,000 public housing residents at 39 service delivery sites. Currently, 26 organizations receive funding under the program, and thus provide services to approximately 48,000 public housing residents at 100 service delivery sites.

In 2000, more than 9.6 million people were served at health centers. Of those, approximately 500,000 were homeless; 600,000 were migrant and seasonal farm workers; and 55,000 were residents of public housing. Also, there were approximately 800 community health centers and/or migrant and seasonal farm worker centers grantees; 130 grantees serving the homeless; and 20 grantees serving those receiving public housing. Each of the grantees may have had more than one site. In total, approximately 3000 health center sites exist.

Success of the health center programs

Since the reauthorization in 1996, the Health Center programs have continued to develop and support a significant number of highly successful, innovative, preventive, and primary health care delivery systems in our Nation's most needy inner cities and rural areas. Health centers provide this care in a cost-effective manner.

Health centers also have effectively addressed major public health concerns (e.g., violence prevention, teenage pregnancy). They have been actively involved with academic health centers in providing community-based training of physicians, nurses, and other health professionals.

Health centers are effective in increasing access to services in needy communities. In 1998, 10.7 million patients were served at health centers—a 4.9 percent increase over 1997. Of those, 4.4 million patients were uninsured—a 7.26 percent increase over 1997—and one-third of those uninsured individuals were children. Plus, 2.4 million patients are enrolled in managed care.

Furthermore, health centers are effective in improving health outcomes, increasing preventive service, improving the management of chronic diseases, and reducing avoidable hospitalizations. In 1998, the percentage of infants born with a low birth weight receiving care from health centers was 7.1 percent—compared to 7.4 percent for all American infants. Given that 57 percent of health center patients belong to a minority group with an increased risk for low birth weight infants, this particular statistic alludes to the comprehensive care that health centers provide.

According to a recent HRSA survey, women who receive their care at health centers are more likely to receive a pap test than

if they were to receive care elsewhere. This increased access to necessary preventive health services also is evident for women who are Hispanic and African-American.

Health center patients are 3.3 times more likely to have controlled blood pressure compared to non-health center patients. Given that more than 43 million Americans are estimated to have high blood pressure—which is a leading risk factor for coronary heart disease, congestive heart failure, stroke, ruptured aortic aneurysm, renal disease, and retinopathy—health centers consistently emphasize care for chronically ill individuals.

Finally, studies comparing health center patients and non-patients show that health centers provide services at a lower cost per ambulatory visit, lower the rate of hospital inpatient days, and lower total costs (including decreased inpatient care costs).

Reasons for health centers success

The committee recognizes that these programs have been successful because health centers offer integrated, high quality, prevention-oriented, case-managed, and family-focused primary care services that result in appropriate and cost-effective use of ambulatory, specialty, and in-patient services. Health centers offer primary care for people in all life cycles, and a range of health and other social services is available on-site or through referrals. The range of services includes health promotion, disease prevention, screening, educational, outreach, and case management services—which are often missing from the traditional delivery of medical services but which are particularly needed by high-risk populations because of their multiple health problems and the significant barriers to access to care that they face.

Health centers also are staffed with full-time primary care providers who are capable of providing culturally competent services to diverse populations. More than 6,715 primary care physicians, nurse practitioners, physician assistants, and certified nurse midwives create the core of health centers nationally. Health centers also have been assisted greatly in attracting and retaining quality providers through the National Health Service Corps.

In addition, the Health Center programs have enabled underserved communities to design and develop their own local solutions to their problems of medical underserved. By supporting the development and operation of health centers at the community level, the health center programs have assured that centers are community-responsive and highly accessible. Residents and patients play an active role in centers' decision-making and planning. By working with local communities and State organizations to plan, develop, and determine priorities for the allocation of resources, the Health Center programs have successfully funded new and expanded programs and services in those communities that are most in need. One measure of the success of these community-based and governed centers is their ability to attract private-pay and privately insured individuals and families, as well as those who are uninsured or covered by Medicaid. Patient payments and third-party insurance payments comprise, on average, 15 percent of health centers' revenues.

Several studies over the years have reported favorably on the quality and cost-effectiveness of the care offered by health centers.

Most recently, researchers found that Medicaid beneficiaries who receive care at health centers were significantly less likely to be hospitalized or to visit hospital emergency rooms for ambulatory care sensitive conditions than beneficiaries who receive care from other providers [Medical Care, Vol. 39, No. 6, June 2001, 551–561]. Other recent studies have found that Medicaid patients who regularly use health centers receive care of equal or greater quality and at significantly less cost than those who use other providers—such as HMOs, hospital outpatient units, or private physicians. In addition, data collected by the Federal Agency for Research on Healthcare Quality (ARHQ) show that health center patients are much more likely to have received the care they need for their condition (such as mammograms and pap smears, or control of blood sugar or blood pressure levels) than other similar populations. These findings are consistent with those from dozens of previous studies on the cost-effectiveness and quality of care provided through the health center model, and in particular, reflect the health centers' demonstrated savings to State Medicaid programs.

Continued need for health centers

Many Americans continue to lack access to basic preventive and primary care services. These individuals are disproportionately poor and represent minority communities. They lack adequate or any health insurance, and they tend to be sicker patients who require more expensive treatment and care. The barriers to access to health care services include:

1. Financial Barriers.—Millions of people lack adequate insurance and/or cannot afford to pay for cost-effective, preventive and primary care services. According to the Kaiser Family Foundation, "In 1999, 42 million Americans—nearly 18 percent of the total non-elderly population—were uninsured. The number of uninsured has grown by nearly 10 million over the past decade. A smaller share of Americans have health insurance for themselves and their dependents through their jobs today than ten years ago, and even more would be uninsured were it not for eligibility expansions and enrollment growth in the Medicaid program." A significant proportion of these people also have incomes under 200 percent of poverty.

2. Geographic and Capacity Barriers.—Currently, a total of 71.9 million people live in areas designated by the Federal Government as medically underserved—37.7 million in urban areas (52 percent) and 34.2 million (48 percent) in rural areas. Of these, a total of 43.4 million lack access to a primary care provider—22.2 million in urban areas and 21.2 million in rural areas. Private practice in these underserved areas has not been economically viable because of low income, and in rural areas, because of low population density. Underserved rural and urban areas also tend to lack professional backup, facilities, equipment, and organizational support. As a result, physicians have not "diffused" into shortage areas to the degree previously predicted, resulting in primary health care practitioner shortages.

3. Transportation, Culture, and Language Barriers.—Health care facilities are often located in areas that are not easily accessible to underserved patients. To assure the timely, effective receipt of preventive and curative care, the availability of transportation and

outreach services is essential. Even where health services are physically accessible, communication and language problems between providers and patients, as well as provider insensitivity to cultural concerns, may impose barriers to care.

4. Decline in Charity Care by Non-Safety Net Providers.—The committee notes that recent studies have found substantially lower levels of charity care among physicians and hospitals in communities with high managed care enrollment (exceeded only by the almost non-existent level of charity care among physicians who refuse to participate in managed care), resulting in an "increased burden on an already fragile safety net." (Cunningham et al, JAMA, November 1999).

The 3.7 million uninsured people whom Federally-supported health centers are able to reach account for only 9 percent of the Nation's uninsured. Both the Congress and the President have recognized the value of the quality, culturally competent care provided by health centers as an ideal model for expanding access to care for the uninsured, and they have called for a doubling of the capacity of health centers to provide care by 2006. President Bush declared in his 2001 State of the Union address, "To provide quality care in low-income neighborhoods, over the next 5 years we will double the number of people serve in community health care centers."

Health centers programs in a changing health care environment

Health centers have done an excellent job of adapting to the changing health care environment. In 1996, the committee permitted the use of grant funds to support the establishment of managed care networks and plans. Health centers all across the country have taken steps to form networks with other local providers and to develop the financial, legal, and business acumen necessary to function effectively in managed care. Almost three-fourths of all health centers are participating in managed care as subcontracting providers to managed care plans—serving more than 2 million managed care enrollees.

As the market continues to change, health centers are joining with each other and with other local providers to form integrated service networks to coordinate and improve their purchasing power and/or to better organize the continuum of care, especially for those who are uninsured. These include practice management networks designed to improve quality through shared expertise (such as centralized pharmaceutical or laboratory services, clinical outcomes management, or joint management/administrative services); to lower costs through shared services (such as unified financial or management information systems, or joint purchasing of services or supplies); to improve access and availability of health care services provided by the health centers participating in the network; or to improve the health status of communities by establishing community-based programs such as vaccine and wellness initiatives. Today, nearly 400 health centers are involved in 50-plus local networks across more than 35 States, each designed to lower costs and improve care. Separately, some 250 or more health centers are participating in statewide or regional collaboratives designed to significantly improve health care management for patients with chronic conditions such as asthma, hypertension, diabetes, cardiovascular

diseases, HIV infections, depression, and environmental health conditions. However, many health centers lack the financial resources to develop these practice management networks, which cannot currently be supported with grant funds under section 330. The committee supports the continued use of public-private partnerships to assist with the provision of health care services.

The committee also heard testimony about health centers' substantial need for support for facility construction, renovation, and modernization. Approximately 65 percent of all health center facilities are more than 10 years old, and 30 percent are more than 30 years old. A recent survey of health centers in 12 States found that approximately two-thirds of them currently need to upgrade, expand, or replace their current facilities. This situation will need to be remedied to meet the intention of Congress to double the capacity of health centers over the next 5 years. The committee recognizes that health centers have faced difficulties in the past because the use of grant funds has been limited in meeting these facility needs.

NATIONAL HEALTH SERVICE CORPS

The National Health Service Corps (NHSC) program was originally enacted by the Emergency Health Personnel Act of 1970 to respond to the geographic maldistribution of primary care health professionals. The NHSC program, authorized through September 2000 under Title III of the Public Health Service Act, is comprised of scholarship and loan repayment programs that provide education assistance to health professions students in return for a period of obligated service in a shortage area. The Corps plays a critical role in providing care for underserved populations by placing volunteer clinicians in urban and rural communities with severe shortages of health care providers.

In 1972, Congress created the Scholarship program to allow health professions students to receive support for their educational costs in return for service in a designated area. In return for each year of scholarship support they receive, students agree to provide services for one year with a two-year minimum service obligation. In 1987, Congress initiated the NHSC Loan Repayment program, under which the Federal Government would agree to repay both governmental and commercial loan obligations incurred by health professionals for their education. In that same year, Congress established a State Loan Repayment program. Under this program, if a State establishes a loan repayment program similar to the NHSC Loan Repayment program, the Department could fund up to 75 percent of the total costs through a grant to the State.

In 1990, Congress reauthorized the NHSC, extending the program for 10 years with the enactment of the National Health Service Corps Revitalization Amendments of 1990 (P.L. 101–597). In reauthorizing the NHSC, Congress made several changes to the program, including a strict prioritization of areas of greatest shortages for placement of new assignees; requirements to include individual assignees' characteristics in making placements; improved incentives for recruitment and retention of health professionals; increased utilization of nurse practitioners, physician assistants, and nurse midwives; and renaming of Health Manpower Shortage

Areas (HMSAs) to Health Professions Shortage Areas (HPSAs). The NHSC authorization expired on September 30, 2000.

During the 1980s, the appropriations for the NHSC scholarships fell from $63.4 million in FY1981 to $0 in FY1989 and FY1990. As a result, the number of physicians and other health professionals with scholarship obligations who were available for placement fell dramatically. On the other hand, funding for the loan repayment program increased in the last half of the 1980s. Between 1990 and 1994, Congress increased NHSC program funding in response to the growth in the number of HPSAs. However, the NHSC is a discretionary program and funding dropped to $112.4 million in FY1998. Funding rose slightly to $115.3 million in FY 1999, $116.9 million in FY 2000, and $125 million in FY 2001.

Currently, 2,376 NHSC clinicians, including physicians, dentists, nurse practitioners, physician assistants, nurse midwives, and mental and behavioral health professionals provide health care services to 3.6 million Americans. The committee notes that due to a lack of adequate funding, the NHSC has a limited capacity to meet the needs of people living in primary care, mental, or dental HPSAs. Indeed, the NHSC meets less than 13 percent of the current need for primary care clinicians and less than 6 percent of the current need for dental and mental/behavioral health services. The committee notes that in many cases, the provision of some health care services would not be possible without the presence of an NHSC assignee, and it further notes that some 15 percent of the 6,500 clinical providers working at health centers are NHSC Scholarship and Loan Repayment recipients. More communities apply for placement of Corps providers than are available through the program.

The committee heard testimony that action needs to be taken to improve the partnership between health centers and the NHSC. Moreover, the capacity of health centers to care for the underserved cannot be doubled without the continued growth of the NHSC and a strengthening of the relationship between the two programs.

AUTHORIZATION OF THE HEALTHY COMMUNITIES ACCESS PROGRAM

More than 40 million adults and children are uninsured today. When the uninsured seek health care, they often utilize a patchwork of unrelated community providers who are willing to care for them, including hospitals, community health centers, rural health clinics, and a host of other providers. The challenges that these providers face in meeting the needs of the uninsured leave little leftover resources to devote to creating an infrastructure to ensure that care is integrated across providers. The Community Access Program (CAP) demonstration project, and its evolution into the Healthy Communities Access Program (HCAP), addresses the need to develop an infrastructure to support coordinated care for the uninsured.

A March 2000 report by the Institute of Medicine (IOM) entitled, America's Safety Net: Intact But Endangered, warned policy makers about a disturbing threat to safety net providers that is jeopardizing access to care for uninsured and disadvantaged populations. One of the major recommendations that emerged from the IOM's report, was to create a competitive grant program to "help support core safety net providers that care for a disproportionate

share of uninsured and other vulnerable people." The IOM proposed a $2.5 billion program over 5 years to address the "challenges of delivering coordinated, seamless care for the poor uninsured and other vulnerable individuals" through the core safety net. The IOM also reported that the CAP demonstration project was a "good first step" to addressing its recommendation. (Institute of Medicine. March 2000. America's Safety Net: Intact But Endangered. 12–14.)

The CAP demonstration program has provided critical support for safety net provider networks that the Healthy Communities Access Program (HCAP) will advance even further. In FY 2000, Congress launched CAP to provide grants to local consortia of hospitals, community health centers, public health departments, and nonprofit providers to enhance collaboration and integration among them. Through appropriations provided in the past two fiscal years—$25 million in FY 2000 and $125 million in FY 2001—76 communities across the country have been funded and are currently in the middle of improving the level of integration among safety net providers. Approximately 50 more grants will be awarded this year. These grants are used to assist safety net providers in developing a community-wide safety net infrastructure, including improved information systems, telecommunications, integrated networks, better case management, and other collaborative initiatives that have a real impact on the quality and efficiency of care provided to the uninsured. The Healthy Communities Access Program (HCAP) is intended to build on the successes of CAP while adding critical disease management components to the grant program.

The Public Health Subcommittee heard testimony about the success of some of the initial CAP grantees. In particular, John O'Brien, CEO of the Cambridge Health Alliance and Chair of the National Association of Public Hospitals and Health Systems, described the exciting initiative undertaken by the CAP consortium in Cambridge. The overall goal of the Cambridge CAP project is to decrease the number of uninsured and underserved in Cambridge, Somerville, and designated surrounding communities. They have set an ambitious target of enrolling at least 50,000 of the 57,000 uninsured in a comprehensive coordinated system of care by the fourth year of this project—building upon an already robust partnership between the Alliance and more than 50 community partners.

The Community Lifeline Project of Hennepin County, Minnesota, is an excellent example of core safety net providers working in collaboration, which includes the local public hospital, community health center network, primary care association, and public health department. This network is using its CAP funding to provide community-based, person-to-person support in navigating the health delivery system for the uninsured. For example, they have enhanced a multi-lingual health information and referral phone line; hired a community health educator and community health workers to assist 2,208 individuals applying for available public insurance programs; arranged for transportation to clinic appointments for patients who might otherwise have been "no-shows"; placed community health workers at the county hospital emergency room and in community clinics to provide health education and information

on the appropriate use of emergency services; and held 15 community-based health education fairs to further enhance outreach to the community.

As another example, the Erlanger Health System in Chattanooga, Tennessee, has assembled a broad coalition of public and private resources to serve a 13-county region across the States of Tennessee, Georgia, and Alabama. Erlanger is utilizing CAP funding to achieve two goals of expanding access to primary care and increasing prevention initiatives. With CAP funding, they have hired community health representatives focusing on three ethnic groups to work with community organizations, churches, and community centers. The representatives assist patients in appropriately navigating the health care delivery and financing system, and they provide some case management assistance. Through further collaboration with the health department and other community organizations, access to health education materials and teaching opportunities has been expanded with increased access to preventive medicine such as vaccinations. Ultimately, the health status of the individual is improved, and they are further empowered to take control of the management of their health care throughout the continuum of care.

In addition to the IOM report and CAP demonstration, the concept of targeting financial support to community networks of safety net providers has been implemented by private sector programs. The W. K. Kellogg Foundation's Community Voices program, launched in 1998, provides grants to 13 communities and supports practical solutions to increasingly severe problems. These communities are influencing the process to identify best practices in meeting the needs of those who receive inadequate or no health services. The Robert Wood Johnson Foundation's Communities in Charge grants help broad-based community consortia design and implement sustainable new delivery systems that manage care, promote prevention and early intervention, and integrate services. Communities in Charge provided grants to 20 communities in 2000, and they continued with second phase funding to 14 communities in 2001. These programs are models of the consensus needed to fill gaps in care to the uninsured. Currently, there is no Federal support other than the CAP demonstration program for communities wishing to build upon the IOM, Kellogg, and RWJ models by integrating the programs and services they already provide into a cohesive system of care for uninsured patients.

III. Committee Action

The Health Care Safety Net Amendments of 2001 was brought up for markup as an original bill at the Health, Education, Labor, and Pensions Executive Session on August 1, 2001. At that time, Senator Kennedy offered an amendment in the nature of a substitute which included several technical changes to clarify the language of the bill, as well as one substantive change. The manager's amendment was accepted by unanimous consent and the committee allowed for the discussion of further amendments.

Senator Clinton offered an amendment to the initial HCAP authorization to amend the underlying bill by altering the authorization level from "such sums" to "$125 million." Some discussion took

place about whether the total funding would be available for the program. The amendment was accepted by voice vote.

Senator Collins offered an amendment to the NHSC to establish a State dental grant program to assist in developing innovative approaches to addressing dental workforce issues. The amendment was accepted by voice vote.

Senator Dodd offered an amendment to establish a school-based health center technical assistance program. After some discussion about whether the amendment would alter the CHC program, the amendment was accepted by voice vote.

Senator Enzi offered an amendment to prioritize new rural grant applications under the CHC program. After some discussion about the need to emphasize the placement of new health centers in rural areas and the additional barriers faced by those areas, Senator Enzi withdrew his amendment after Senators Kennedy and Frist agreed to work to accommodate those concerns.

Senator Hutchinson (for himself and Senator Collins) offered an amendment to provide for part-time demonstration authority within the NHSC. The amendment was accepted by voice vote.

Senator Hutchinson also offered an amendment to alter the definition of a migrant farm worker to clarify that the migrant health centers should also provide services to farm workers who migrate year round. The amendment was accepted by voice vote.

Senator Reed offered an amendment to require the Secretary to establish a demonstration program for the inclusion of pharmacists and chiropractors in the NHSC. This amendment altered the underlying bill which provided for a chiropractor demonstration project. After some discussion about the necessity of increasing the types of providers included under the NHSC, the amendment was accepted by voice vote.

Senator Roberts offered one amendment that included two different grant programs—the mental-behavioral telehealth grant program and the grant program for emergency medical services in rural areas. The mental-behavioral health telehealth grant program is a demonstration project to provide mental and behavioral health services to children and elderly residents of long term care facilities located in mental health professional shortage areas. The rural EMS grant program would provide grants to enable the provision of emergency medical services in rural areas by recruiting and training medial service and volunteer emergency medical service personnel, acquiring emergency medical services equipment and personal protective equipment, and educating the public. This amendment was accepted by voice vote.

The final bill with all of the amendments was reported favorably from the committee by voice vote.

IV. Explanation of Bill and Committee Views

CONSOLIDATED HEALTH CENTER PROGRAM

Introduction

The committee recognizes that over the past 35 years, health centers have proven their durability as a model health care program and their resilience in adapting to a dramatically changed American healthcare system while maintaining their original mission and purpose. The committee bill reauthorizes the Health Cen-

ters program for another 5 years at an increased level of $1.368 billion initially in FY 2002, and it notes the broad Congressional support for the Health Centers program. This support also has been demonstrated through a bipartisan commitment to double the capacity of the program to provide health care services to millions of medically underserved individuals over a 5-year period. Health centers are a critical part of addressing the needs of uninsured and low-income populations for care, and by setting an authorized level of $1.368 billion for FY 2002 (a 17 percent increase), the committee endorses the plan to double the capacity of health centers over 5 years.

Definitions

The term "health care provider" used throughout the Health Care Safety Net Amendments of 2001 is meant to denote both individual clinicians as well as specific points of care (hospitals, clinics, public health departments).

Also, LUIR refers to hospitals with Low Income Utilization Rates of 25 percent or more. The committee chose to use this standard because it is a commonly accepted measure of the amount of care provided to uninsured and Medicaid patients by many hospitals.

New and Optional Services Provided by Health Centers

To assist health centers in better meeting the needs of the communities they serve, the committee bill makes slight revisions to the required primary health care services that health centers must provide and permits health centers to apply for grant funds to provide new, additional services. Within required services, the committee bill expands the types of cancer screenings from breast and cervical cancer screenings to all appropriate cancer screening. The committee bill also clarifies that referral services include referrals to specialists when medically indicated. Case management services are expanded to include housing services. The committee notes that the uninsured and underserved individuals served by health centers often face additional barriers to health care services, such as homelessness and poverty. The committee recognizes that health centers have always worked to connect their patients to appropriate support services that promote and optimize care, and the committee reaffirms the vital role that strong linkages to housing and social services play in the provision of health care services by health centers to the vulnerable populations they serve.

The committee bill also increases the types of additional health services for which grant funding may be provided by adding behavioral and mental health services, public health services, and recuperative care services as services that health centers can choose to provide. It is the intent of the committee that, so long as sufficient appropriations are available, all new start health centers should include mental and behavioral health services as part of their service package, and that existing health centers be encouraged to develop and offer such services. The committee recognizes that behavioral, mental health, and substance abuse services are important primary health services.

There are many indicators of the need for these services, including surveys of Community Health Centers by the National Association of Community Health Centers, the large number of HRSA-des-

ignated Mental Health Professional Shortage Areas, and the Surgeon General's Report on Mental Health, which reveals that one out of five adults and children suffer from mental illness in a given year. It also indicates that mental health problems are particularly acute in underserved areas throughout the Nation. Indeed, mental illness was the fifth most common reason for a visit to a health center in 1999.

The committee recognizes that many urban and rural communities served by health centers face a range of environmental health factors that may adversely affect the health of individuals living in those communities and further exacerbate chronic conditions, including exposure to lead, chemicals, pesticides, and pollution. Health centers can play an integral role in addressing these environmental health concerns. The committee bill revises the definition of "environmental health services" to permit health centers to offer the detection and alleviation of chemical and pesticide exposures, the promotion of indoor and outdoor air quality, and the detection and remediation of lead exposures. Additionally, the committee bill allows the Secretary to make technical assistance grants to health centers to assist in the provision of environmental health services that are appropriate for the individuals and communities they serve.

Public-Private Partnerships

Health centers have been particularly resourceful in developing partnerships with private entities to assist with the provision of health care services. Not only do these partnerships assist with the referral to specific specialists who are not employed by the center, but they also assist with the provision of other wraparound services to assist patients in accessing the center itself. We encourage health centers to continue forming these crucial public-private partnerships.

S–CHIP

Since the reauthorization of the Consolidated Health Centers in 1996 and the National Health Service Corps in 1990, an important public program to increase health insurance access for children—the State Children's Health Insurance Program (S–CHIP)—has been instituted. Given that one-third of the patients served at health centers are children and are likely eligible for S–CHIP, the committee has added provisions in both programs to encourage Corps clinicians and health centers to form contracts and seek reimbursement from this valuable program. Also, pursuing outreach opportunities to enroll people in S–CHIP will prove beneficial for both the medically underserved and community providers.

Health center services available to all regardless of ability to pay

The committee notes that health centers have always provided their services to all residents of their service areas, regardless of the ability of an individual, or of his or her family, to pay for such services. Traditionally, health centers have limited the provision of services based only on the capacities of the health center facility, its personnel, and the financial resources available to the health center to provide services to residents of the area. The committee is adding language to the bill to emphasize this commitment to pro-

vide services to all, by requiring health centers to provide explicit assurances that no patient will be denied health care services due to an ability to pay.

The committee intends that this new requirement will be performed in a manner consistent with the operational and financial resource limitations of a particular health center to provide care within its service area. Accordingly, if a health center reaches capacity, it may limit the provision of services as long as it does so consistently across all populations served and without discriminating against any individual based on ability to pay or coverage by public insurance programs.

Health centers are fully authorized to waive all fees for individuals and families below 100 percent of the Federal poverty level. Should health centers determine that a nominal fee is appropriate for those below Federal poverty level, that also would be acceptable provided that no health center should ever deny its services for inability to pay.

Meeting facility needs

The committee finds that addressing the facility needs of health centers is the most critical problem that must be solved if they are to continue providing care for the underserved of this country. The committee recognizes that many health centers operate in facilities that desperately need renovation or modernization. Also, to expand health center services to new communities, many health centers may need to build new facilities, renovate, or modernize existing facilities in the area where the services will be provided. The committee notes that health centers have limited financial capacity to undertake needed facility improvements, expansions, or new site developments—while simultaneously serving a large and growing patient base on slim operating margins.

The committee bill has provided a variety of options to respond to the capital improvement needs of the Nation's health centers. First, the committee has restored the Secretary's authority in section 330 to make grants to health centers for capital projects, which was eliminated in the 1996 reauthorization. The elimination of this authority has made it extremely difficult for health centers to meet facility needs. The committee notes that by allowing health centers to use both planning/development and operational grant funds for construction, modernization, and expansion, the ability of health centers to meet the demand for health care services in existing and new communities will be greatly enhanced. The committee also believes that restoring construction, expansion, and modernization authority in section 330 advances the goals of the Resolution to Expand Access to Community Health Centers (REACH) Initiative sponsored by Senators Bond and Hollings, which calls for doubling the capacity of health centers to provide care to as many as 10 million more Americans over a 5-year period.

The committee understands that, in most cases, grant funds will be used to pay part of the costs of facility needs—particularly in the case of larger facility construction or modernization projects. In these situations, health centers also will need to secure long-term financing to meet the remainder of the costs. No loan, loan guarantee, or grant may be made for a project involving the moderniza-

tion of a building unless the project complies with the Davis-Bacon Act and wages are paid at locally prevailing rates.

The committee intends to give the Secretary flexibility to support the costs of capital projects, particularly in rural areas and blighted urban areas where no existing facilities are available for acquisition and modernization. The committee does not intend that limited grant dollars for health services be redirected to capital projects. In order to conserve grant funds, the committee expects health centers to make every effort to utilize available commercial financial sources for facility acquisition, construction, modernization, and expansion needs. To ensure that the vast majority of funds appropriated under section 330 are used for patient care, the committee has limited the amount of funds that can be used for construction, renovation, and modernization of facilities in any fiscal year to no more than 5 percent of the total amount appropriated under section 330 for that fiscal year.

Loan guarantee

The committee is concerned that the loan guarantee program, which in the past has only provided a guarantee for 80 percent of the loan value with waivers for 85 percent and 90 percent has been difficult for health centers to utilize due to a number of issues. The committee recognizes that most health centers, as non-profit organizations dedicated to making health care available to the most needy in their communities, have little or no financial reserves and would otherwise encounter great difficulty securing long-term financing from local lending institutions at reasonable interest rates, if at all. At the same time, construction costs have soared over the past few years, and as a result, the gap between what health centers can afford and the cost of capital projects continues to grow. For this reason, the committee bill extends the existing authority, which currently permits the issuance of loan guarantees for managed-care purposes, to include loan guarantees for facility construction, modernization, and expansion, and for acquisitions of facilities and equipment. The committee authorizes the Secretary to issue guarantees for up to 90 percent of the principal and interest on loans made to health centers for capital projects. Hopefully, this legislation will provide the appropriate balance between the Government's duty to ensure safe and effective health centers and the local investment in the health care infrastructure.

Use of leftover funds

The committee has been advised that only a small portion of funds has been expended as previously appropriated under section 330, which were available for loan guarantees for health centers for fiscal years 1997 and 1998, under the Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Acts of 1997 and 1998, respectively. These funds were made available for loan guarantees under Title XVI of the Public Health Service Act for loans made by non-Federal lenders for the construction, renovation, and modernization of health center facilities, as well as for guarantees for loans to health centers for the costs of developing and operating managed care networks or plans under section 330. A total of $14 million was appropriated for the 2 fiscal years, which under the terms of the Federal Credit Re-

form Act of 1990, allowed the issuance of up to $160 million in loan guarantees. Because of difficulties in the administration of the loan guarantee program—which the committee bill remedies—very little of the $160 million in guarantees were actually issued. Indeed, only $21 million in guarantees has been spent to date, leaving $139 million available. The committee bill makes these funds available until expended for loan guarantees under the newly revised Section 330(d) of the Public Health Service Act.

Solvency study

The committee recognizes that many health center-owned or controlled managed care organizations are concerned about the difficulty in meeting State solvency requirements for loans. The committee also understands that health centers face many financial burdens in trying to deliver health services to the underserved, and innovative ways must be found in guaranteeing solvency for loans taken by organizations. For that reason, the committee requests the Secretary to conduct a study that would examine the feasibility, costs, and implementation requirements of establishing a program to provide Federal guarantees to health center-owned or controlled managed care organizations so they could meet State solvency requirements. The Secretary shall provide this report to this committee, and other appropriate committees, no later than 2 years after the date of enactment of this legislation.

Refinancing of loans

Refinancing of existing loans will enable health centers to reduce interest payments or improve loan terms. To be eligible to use the loan guarantee authority for refinancing, a health center must demonstrate that it would be beneficial to the health center and the government. The committee believes that these provisions will allow health centers greater access to capital with potentially lower interest rates, resulting in lower overhead costs and timely completion of capital projects. Also, funds previously used for high interest payments will be able to be used instead to provide health care services for the underserved.

Practice management networks

Health centers have been quick to respond to the changing dynamics of health care delivery by collaborating with each other and with other local providers in networks and partnerships designed to improve quality and access to care. These relationships also achieve efficiencies in care delivery. Examples of these networks include clinical collaboratives, shared computer information systems, and shared administrative and financial support systems. To assist health centers in these efforts, the committee bill expands the current authority supporting network development and operation under section 330 by creating a new category of networks called practice management networks. Health centers will be able to apply for grant support for networks that reduce costs, enhance the quality and coordination of health care services, improve the availability and access to health care services, and improve the health status of communities.

In developing the practice management networks in this reauthorization (in addition to the managed care networks which were

added in 1996), it became obvious that a more efficient payment system for those networks would allow the Secretary to directly provide funds to those networks, rather than requiring the Secretary to provide funds to each of the entities in the network separately. To ensure that the networks and the funds provided by the Secretary are still under the control of each of the health centers within the network, those networks are required to be at least majority owned or majority controlled by the health centers, and the health centers make the request to the Secretary for the network payment.

The committee bill permits the Secretary to make grants under section 330 to develop and maintain these new practice management networks and continue the use of section 330 funds for the planning and development of managed care networks. The committee bill further clarifies that health centers may receive planning and development support for the establishment of practice management networks, and that networks which are owned and/or controlled by section 330 funded health centers may receive limited operational support. Funds may be used to purchase or lease equipment (including data and information systems) and to provide training and technical assistance that will assist in the development and maintenance of these networks. To ensure that the majority of section 330 funds are used for direct patient care, the committee bill limits funds for all network purposes (both practice management networks and managed care networks) to no more than 2 percent of funds appropriated in a fiscal year. Additionally, the committee believes that no construction funds should be allocated to practice management networks or managed care networks, but should be reserved for individual health centers.

Proportional funding allocation

The committee restores the statutory funding allocation requirement for the Community Health, Migrant, Homeless, and Public Housing subauthorities under section 330. The committee notes that when the four separate health center programs were consolidated under a single section 330 authority in 1996, the law included a requirement for allocating funds appropriated under section 330 for each of the subauthorities in accordance with the proportion of total funding they each had received in FY 1996. The committee recognizes that despite the fact that this statutory funding allocation requirement expired in 1998, the Secretary has continued to adhere to the methodology in distributing overall Health Centers program funding among the four health center programs subauthorities. Vulnerable populations have benefitted from the Secretary's actions because the migrant, homeless, and public housing health center programs provide specialized care to these populations. These programs should be continued and expanded, and restoring the original funding allocation methodology to the statute would ensure the continued distribution of section 330 funds to farm workers, homeless persons, and public housing residents. The committee would like to stress the desire to maintain appropriate funding levels for each of the programs, and we commend the Secretary for continuing to allocate the same percentage each fiscal year as was allocated the previous years.

Eligibility of farm workers and homeless individuals

The committee notes that during consolidation of the Health Center authorities in 1996, eligibility for services under the homeless program of formerly homeless individuals during the first 12 months following their transition to permanent housing was inadvertently omitted. Also, current authority fails to specify homeless youth as eligible for services, even though they remain a key homeless population. In addition, current law fails to recognize many farm workers as eligible for services because they migrate year-round for employment purposes. The committee bill provides access to care for these individuals by permitting farm workers who move year-round to receive services from farm worker health programs. It also provides coverage to homeless youth and formerly homeless persons following their transition to permanent housing. The committee believes that these provisions ensure that the Health Centers program remains appropriately targeted to the most vulnerable populations.

Nurse-managed health centers

Nurse-managed health centers are nationally recognized safety-net primary health care providers in urban and rural areas. The majority of nurse-run health centers have been established by non-profit, university-based schools of nursing to meet the needs and interests of community members and to prepare qualified graduates with the skills to work in medically underserved areas. Many of these health centers were originally funded by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Bureau of Health Professions and Division of Nursing. Critical goals for the nurse-managed primary care health centers include attaining Federally Qualified Health Center status and becoming contributing members of the Consolidated Health Centers Program.

Nurse-managed health centers are eligible to receive section 330 funding (or to be certified as FQHC look-alikes) in accordance with section 330(e)(1)(B), which allows the Secretary to fund an entity for which s/he is "unable to make each of the determinations required by subsection (j)(3)" [including the governance requirement under (j)(3)(H)] for up to 2 years. The committee encourages HRSA's Bureau of Primary Health Care to expedite FQHC certification and, where appropriate, provide 330 funding to nurse-managed health centers, which were previously and are currently funded by HRSA, Bureau of Health Professions, Division of Nursing, and to provide technical assistance during this 2-year period to enable the nurse-managed health centers to achieve full compliance with all 330 requirements, and thus, remain eligible for continued health centers funding.

Outreach and services for special populations

The committee bill contains a new requirement that health center boards review all internal outreach plans for specific subpopulations in order to ensure community involvement in these efforts. However, the committee does not intend that this requirement prevent health centers from engaging in outreach activities in response to pressing local health needs before the health center board is able to review a plan before the outreach activities are needed.

It is the committee's intention that community health centers be accorded considerable flexibility in the development of their outreach and services plans, in recognition of the variations across communities with regard to the prevalence of the various subpopulations, the needs of people in those subpopulations, the availability of targeted subpopulation services, and the availability of resources.

The committee instructs the Secretary to provide guidance to community health centers with regard to the service modifications they may wish to consider as they develop their subpopulations outreach and services plans. Such modifications may include establishment of advisory or focus groups; posting of notices of hours of service and fee schedules at locations where subpopulations congregate; adjustments in eligibility determination processes, appointment systems, and hours of service; outstationing of health center staff at emergency shelters or other locations where members of subpopulations congregate; addition of services for health conditions common among people in those subpopulations; in-service training of health center staff about subpopulations; establishment of referral relationships for case management and supportive services with public entities and faith-based organizations; or other locally appropriate activities. Further, the committee instructs the Secretary to provide guidance to community health centers in developing subpopulation outreach and services plans.

Finally, it is the view of the committee that health centers should be encouraged to make contractual and collaborative arrangements with entities that currently provide health and support service outreach to targeted subpopulations, including the homeless, migrant and season farmworkers, and residents of public housing.

Availability of translation services

The committee recognizes the critically important role that translation services, as well as health care services provided in a culturally competent manner, play in ensuring the delivery of appropriate health care services to patients with limited English proficiency. The committee applauds the efforts of health centers to deliver linguistically and culturally appropriate care. It recognizes and appreciates that health centers serve increasing numbers of patients speaking a variety of languages and representing diverse racial and ethnic backgrounds. It is acknowledged that it is often the case that grants to health centers under section 330 do not adequately cover the full costs of providing needed language access services to the continually increasing variety of populations and languages served by the health center. The committee directs the Secretary to work with health centers to enable them to provide, to the maximum extent feasible, appropriate language access services for all of the patients with limited English proficiency. This includes permitting the Secretary to award grants to health centers to provide translation and interpretation services or to compensate bilingual or multilingual staff for language assistance services for limited-English proficiency patients. The committee encourages the Secretary to keep the grant application process from being overly burdensome for the applicants and to allow creativity and flexibility in considering the various ways that grantees can provide

language access through these funds. The committee bill authorizes $10 million in FY 2002 for these grants, in addition to the amounts authorized for the Health Centers program.

Technical assistance for health centers and new starts

The committee bill revises the current technical assistance authority to require the provision of additional information to organizations that wish to become health centers and current grantees and requires the provision of information on resources available to assist entities to meet the health needs of communities.

State-wide technical assistance centers for school-based health

The committee bill authorizes a new program for school-based health centers that may not be receiving section 330 funding to create new organizations to fund current programs to establish statewide technical assistance centers. These groups will coordinate Federal, State, and local health care services that contribute to the delivery of school-based health care; provide technical support training; and conduct operational and administrative support activities for statewide, school-based health center networks. The committee authorizes $5 million to be appropriated for fiscal year 2002 for these centers.

RURAL HEALTH

The Rural Health Outreach and Network Development Grant Programs serve to support innovative health care delivery systems, as well as integrated health care networks in rural America. Since 1991, more than 2.7 million people in 46 States have been served by the Outreach Grant Program through grants that total more than $200 million.

In re-authorizing this program, the committee has made changes to the authorizing language to recognize that the Rural Health Outreach Service Grants and Network Development grants serve different purposes and are administered separately. The committee supports the notion that Outreach Services grants are focused on improving health care service delivery, while the Network Development grants are focused on helping rural communities improve their capacity building efforts to strengthen the rural health care infrastructure.

The committee also has added a new program to the Outreach authority entitled, "the Small Health Care Provider Quality Improvement Grant Program." This program will provide grants to small rural health care providers for projects to improve quality and enhance how they deliver care to rural communities.

The Rural Health Outreach program has been essential for the delivery of quality health care for millions of individuals living in rural underserved areas. Both Outreach Services and Network Development programs include requirements for working with other organizations and providers to achieve program goals. This aids buy-in across rural communities and ensures the continued viability of the project after Federal funding is complete. The benefit of this requirement has been to foster collaborative relationships between privately practicing health professionals, hospitals, schools, churches, emergency medical service providers, and local health departments.

The committee is aware that many rural providers have had difficulty accessing the capital necessary to expand services, form networks, or develop quality improvement programs. The three grant programs authorized by this legislation are intended to make resources available for these important activities.

The focus of each of these grant programs is on expanding access and improving the quality of health care services being delivered in rural communities. The committee encourages the Secretary to ensure an equitable distribution of funds across the States. The committee notes that the nature of rural communities varies significantly across the country. Rural Montana is different than rural Massachusetts. Consequently, the committee encourages the Secretary to provide support for a diversity of projects that reflect the varied nature of rural populations. The committee also wants to ensure that the program can build on existing models that work.

In designing these grant programs, the committee paid particular attention to the need to focus on service delivery. Equally important, the committee felt it was essential to design these programs to reflect the reality of the communities the projects seek to assist. For example, while both the Outreach Services and the Network Development grants require that the project reach out to other local partners, the Small Health Care Provider Quality Improvement grants do not have a similar requirement. Instead, applicants for the Small Health Care Provider Quality Improvement grants can be either public or private for-profit entities. The committee makes this distinction because in many small, rural underserved communities, the safety net has a much broader definition than in non-rural areas, and it is the privately practicing physician who represents the most likely applicant. These privately practicing physicians represent an important part of the health care safety net in the United States. The committee wants to acknowledge their important contribution to making health care accessible and affordable. The committee is confident that the reauthorization and expansion of this important program will provide much needed assistance to rural underserved communities not previously supported by the program.

Subtitle B of the bill would consolidate various telehealth grant programs and establish the Office for the Advancement of Telehealth (OAT). The bill also identifies OAT as the office that shall administer these telehealth grant programs.

Telehealth offers great promise for improving access to specialized health care services in rural communities. By consolidating the grant programs, the committee hopes a more coordinated effort will be created to bring telehealth services to rural areas while encouraging the creation of a network of users for these services.

The legislation also would support the establishment of telehealth resource centers throughout the United States. These centers would provide technical assistance to entities interested in putting together a telehealth network. Furthermore, these Resource Centers would be available to demonstrate how telehealth technology can be used effectively in rural communities.

Finally, the committee asks the Secretary to develop a definition of frontier areas to ensure that communities which are isolated will be served by the programs established by Congress—with the highest benefit possible. A new definition of frontier is necessary to en-

sure that resources targeted to this area are given to the areas of greatest need. The committee strongly urges that the definition be completed within one year after the enactment of this legislation.

NATIONAL HEALTH SERVICE CORPS PROGRAM

Expanding and strengthening the NHSC

The committee recognizes the critical role the NHSC plays in providing care for underserved populations by placing clinicians in urban and rural communities with severe shortages of health care providers. Although the NHSC program has proven successful in addressing health professional shortages in many areas, funding limitations have restricted the program's ability to meet its primary goal. The committee notes that according to HHS, more than 12,000 physicians (4 times the current number of NHSC providers), would be needed to place sufficient providers in all health professions shortage areas. More than 20,000 physicians (8 times the current number of NHSC providers) would be needed to bring all areas of the country to the same staffing ratios for providers that are used by both managed care organizations and health centers. To increase the ability of the NHSC to meet staffing needs in underserved areas, the committee bill reauthorizes the National Health Service Corps (NHSC) program for 5 years, with the intention that the level of funding for the program be doubled over that period. For FY 2002, the committee authorizes a 17 percent increase to a level of $146.75 million and such sums as may be necessary for the following 4 years.

Automatic HPSA designation

The committee recognizes that the NHSC, the Health Centers, and Rural Health Clinics Programs are intended to address the same goal: to meet the health care needs of underserved populations. Requiring a health center to obtain a Health Professional Shortage Area (HPSA) designation, even though each health center already serves a "medically underserved area or population," creates a bureaucratic hurdle to the placement of NHSC personnel at health centers. The committee believes that providing automatic HPSA facility status to health centers and rural health clinics, thus making them eligible for placement of NHSC personnel, will reduce bureaucratic barriers and allow coordinated use of Federal resources in meeting the health care needs of areas that lack sufficient services.

To be eligible for an NHSC placement, health centers and rural health clinics will receive automatic designation as a HPSA for a period of 5 years. After that period, a rural health clinic or a health center would be required to demonstrate that its HPSA designation complies with the HPSA requirements in effect at that time. The committee feels that this provision strikes an appropriate balance—it prevents health centers from being "grandfathered" in without adequately meeting the standards needed to receive an NHSC placement, and at the same time, it reduces the bureaucratic burden health centers may face in retaining their designation. The committee believes that this automatic designation process will improve the partnerships between health centers, rural health clinics, and the NHSC.

Assignment of Corps personnel

The committee bill revises the law to permit the assignment of Corps personnel to for-profit sites, and provides that priority in placements will be given to nonprofit and public sites. It is the intent of the committee that the Secretary carefully examine and limit the instances in which placements are made in for-profit sites. Assignments of Corps personnel should be made to safety net providers serving a HPSA whenever possible and to support their work in caring for the uninsured and underserved.

The committee recognizes that in some rural areas, communities may not have particular non-profit or private entities who can serve as placement sites for Corps members, even though those communities are designated as health professional shortage areas. To increase access to clinician services in those areas, the committee has allowed for-profit sites to be eligible for the program, but restricts such inclusion to areas in which lack non-profit or private sites.

Determining priorities for placement of NHSC personnel

While intended to ensure that all Corps placements were made in areas of highest need, the committee believes that the current criteria used to determine whether a NHSC site is included on the high priority placement list has actually had the effect of discriminating against areas of high need and the safety net providers serving these areas because the criteria severely restricts the Secretary's flexibility to consider factors not listed in current law as indicators of need. The committee bill repeals these restrictive criteria, giving the Secretary flexibility to take into account a broader range of documented access barriers in an area or population, such as linguistic or cultural isolation, transportation barriers, and other factors highly correlated with underservice—including the size of the uninsured, elderly, disabled, or minority populations. In determining priorities for placement, the Secretary may continue to use the criteria previously used—ratio of health professionals to the number of individuals in the area of population served or served by the medical facility to be designated, as well as the rate of low birth weight births, infant mortality, poverty, and access to primary health services. However, the Secretary is no longer limited to the use of just these criteria.

Revision of process for determining placement on the priority list

The committee bill establishes a new process for the development of the priority placement list, and HRSA should report back to the committee with the new HPSA regulation and how it will be implemented. The Secretary is required to publish a proposed list of HPSAs and entities that would receive priority in NHSC placements, and the relative scores and priorities of all entities applying for NHSC placements. All entities will have 30 days after the publication of the list to provide additional information to the Secretary in support of inclusion on the priority list or in support of a higher priority determination. After reviewing the information, the Secretary is required to publish a final list. Entities eligible for NHSC placements shall be notified that they are authorized to receive a placement. The Secretary may periodically update the final list and add new entities, and if the Secretary does so, entities ad-

versely affected by the update shall be notified by the Secretary and shall have 30 days to file an appeal. The committee notes that these new due process rights are a central part of many other statutes and are important to providing for the development of the priority list for the NHSC. This is important in view of the consequences of the loss of HPSA designation or priority status to areas that had previously been considered high-priority shortage areas.

Residencies

The committee recognizes that obligated physicians who have not completed residencies are less prepared to fulfill their service obligation, have extremely limited placement opportunities, are less successful in competing for site assignments, and are having increasing difficulty in obtaining hospital admitting privileges. To correct this situation, we are amending current law to require physicians to complete a full primary care residency program and extend deferment for advanced training to include all disciplines eligible for the Corps scholarship program. Residency-trained physicians are best qualified to deliver a full range of services required by underserved communities. Based on data from the Corps loan repayment program, there is less difficulty in placing clinicians of all disciplines as a result of additional training obtained prior to the start of their service obligation.

Termination and other contractual changes

The committee recognizes that the statute of limitations applicable to both the scholarship and loan repayment programs gives the Federal Government 6 years from the date a debt becomes due to file a complaint in District Court. If a complaint is not filed within that time, the agency has no alternative but to terminate collection efforts and write off the debt. Furthermore, the period of absolute non-dischargeability is currently 5 years. Although the current service obligation under the scholarship and loan repayment programs is identical, the default provisions are different: the unserved obligation penalty under the loan repayment program is only $1,000 per month. Also, under the current default/termination authority, the scholar who refuses scholarship support, in whole or in part, may convert his or her service obligation to simply repay the amounts received. Therefore, an individual could accept 95 percent of the scholarship for a year, refuse 5 percent, and be able to avoid the service obligation and the triple payback penalty for that year.

To enhance the Secretary's effectiveness in collecting debts from defaulting Corps clinicians, the committee has instituted a variety of changes, including eliminating the statute of limitations applicable to the program so that the Government can continue to pursue debts that are currently being written off, increasing the period of non-dischargeability from 5 to 7 years to give the Government added protections against having these debts discharged in bankruptcy, and revising the loan repayment default provision by increasing the unserved obligation penalty from $1,000 to $7,500 per month. The value of the loss of a clinician's services to an underserved community (upon default) should be roughly equal under both the scholarship and loan repayment programs. However, the

average loan repayment debt is $57,948, while the average scholarship debt is $252,296.

Furthermore, the committee grants the Secretary authority to terminate loan repayment contracts, at the request of individuals who find that their loan repayment service is not amenable to their needs, provided the individuals return all monies awarded in sufficient time to enable the program to reobligate those monies to another loan repayment applicant. Therefore, the committee has waived the unserved obligation penalty otherwise owed by defaults.

The committee would like to require scholars who refuse scholarship support to repay all funds received during a school year by the end of that contract/school year. Thus, scholars would have an incentive to decline support earlier rather than later in the school year. To institute that change, the committee has included language to require the refusal of all funds received, rather than just part of the funds.

Overall retention rates

The committee is heartened by recent reports suggesting that Corps clinicians serve for several years beyond completion of their service commitment. In 1995, approximately 53 percent of eligible clinicians continued to provide valuable services to underserved communities after their obligation was fulfilled. That percentage has steadily grown to 64 percent in 1996 and 1997, and 1998 data reveal that more than 70 percent remain in service. Of these clinicians, approximately 80 percent remain in service at the site at which they originally served. These results vary only slightly by type of clinician. Physicians were retained at a rate of 71.2 percent and nurse practitioners at a rate of 76.8 percent. Loan repayers report a consistently higher rate of retention over scholars. In 1998, loan repayers were retained at a rate of 75.5 percent, while scholars were retained at a rate of 61 percent. Both rates have increased from the 1996 and 1997 levels.

NRSA option

The Corps aims to provide access to primary health care services. The Corps scholarship program provides scholarship support to scholars with the intent that they provide health care in underserved areas, whereas the National Research Service Award program at NIH trains participants in the research field to become academic faculty members. When those participants begin their research, they are oftentimes not available to provide primary health care services to underserved communities. Currently, there are 26 Corps scholars participating in the NIH program out of the 669 scholars in residency training. Therefore, the committee has opted to eliminate the provision which allows scholarship recipients to fulfill their service obligation by participating in the National Research Service Award program.

Repeal of section 334 cost sharing provisions

The committee bill repeals Section 334 of the Public Health Service Act ("Cost Sharing"), which requires that an entity to which a member of the NHSC is assigned must reimburse the Federal Government for the cost of that NHSC member. The committee notes that, in practice, this requirement is waived in almost all cases.

For example, in 1998, the cost-sharing requirement in section 334 was waived in at least 95 percent of cases, and the cost of collecting the remaining 5 percent of payments exceeded the funds received. The committee recognizes that eliminating this provision will relieve the undue burden on underserved communities in seeking an NHSC clinician and the unnecessary administrative burden on HRSA. The committee believes that the dollars saved by eliminating this provision can be better used in providing access to care. The committee further clarifies that this action is consistent with the spirit of the Paperwork Reduction Act and will facilitate increased usage of NHSC clinicians by underserved communities.

Charges for services

After completing their taxpayer-funded medical education, many NHSC Scholars request (and HHS often approves) a waiver of their NHSC service obligation if they agree to establish a "private practice option" (PPO) in a designated HPSA. Under current law, the Scholar is free to practice in virtually any HPSA, whereas those who fulfill their service obligation through assignment are targeted to high-need HPSAs. Currently, these "private practice option" clinicians are not subject to the requirement that they open their practice to all in the community regardless of ability to pay, and in some cases, these NHSC-subsidized for-profit practices have been found to resist caring for uninsured (and even Medicaid-covered) patients and refer them instead to nearby health centers and other local safety net providers.

The committee bill sets out the requirements that entities with Corps placements must comply with when providing services. These rules apply to all entities with NHSC assignees, as well as NHSC members who elect the private practice option (PPO). The bill prohibits discrimination in the provision of services to an individual because the individual is unable to pay or because the individual has coverage under the Medicare, Medicaid, or S–CHIP programs. Assignment under Medicare must be accepted, and cooperative agreements must be entered into with the State agencies administering the Medicaid and S–CHIP programs. The local and prevailing rate for services may be charged in an amount designed to cover the cost of the entity. However, if an individual is unable to pay the fee, the charge must be reduced or waived in accordance with a schedule of discounts that are based on the individual's ability to pay for services.

The committee reiterates that this provision is included to ensure that the NHSC is used to reduce access barriers for everyone living in communities lacking health professionals, regardless of their income or ability to pay for services. The committee directs the Secretary to monitor compliance with this requirement by entities with NHSC assignments, as well as individuals electing the PPO option to determine whether services are being provided to patients regardless of ability to pay and without discrimination against individuals with coverage under public programs.

Part-time service

To assist with both recruitment and retention within the National Health Service Corps, the committee creates a demonstration program to allow NHSC Loan Repayment participants to complete

their service requirement on a part-time basis on written request of the placement site. Participants in the part-time program must work at least 16 hours per week and must agree to extend their service obligation so that the full service obligation is completed. The committee bill includes this provision in order to better meet the needs of the communities in which NHSC Loan Repayment participants serve and to enhance recruitment and retention efforts. In particular, the committee recognizes that many small rural communities may not have sufficient volume to support a full-time health care practitioner. In addition, some sites may not need particular types of providers on a full-time basis. The committee believes that some practitioners may find part-time service more attractive, which in turn could improve both recruitment and retention. Not only will this demonstration project provide for added flexibility within the program, but the committee hopes that it will also assist with the recruitment of women within the program.

Set-aside for non-physician primary care practitioners

In 1990, when the National Health Service Corps was last reauthorized, nurse practitioners, certified nurse midwives, and physician assistants were not receiving scholarships. Instead, they only received loan repayments. To emphasize that the Corps was not a physician-only program, the committee provided these groups with a 10 percent scholarship set aside. However, over the past 10 years, communities have developed an overall preference for receiving loan repayment clinicians, rather than having scholarship recipients. For example, in the 2001 placement cycle, there were only 163 vacancy requests for nurse practitioners, certified nurse midwives, and physician assistants for 150 scholars available for service, while more than 30 percent of the loan repayors placed within the underserved communities were nurse practitioners, certified nurse midwives, or physician assistants.

Thus, the committee believes that the set-aside for these providers should be expanded to include both the scholarship and loan repayment portions of the Corps. This decision should not be construed to indicate that the committee does not support the placement of such groups in underserved areas. In fact, we believe quite the opposite—the placement of such groups is critical to the success of the Corps. It is an indication of the community requests and their changing needs. Furthermore, to maintain the incentive for providing scholarships to nurse practitioners, certified nurse midwives, and physician assistants, those clinicians should be counted for both the scholarship set-aside (30 percent of funds) and the nursing set aside (10 percent). With this change, the committee also hopes that the Secretary will re-evaluate the scholarship program and appropriately target it so that the scholarships can be given to minorities and individuals with financial need, and that the communities with greatest need will obtain appropriate clinicians.

Dental health

Oral and general health are inseparable, and good dental care is critical to our overall physical health and well-being. While oral health in America has improved dramatically over the last 50

years, these improvements have not occurred evenly across all sectors of our population, particularly among low-income individuals and families. Too many Americans today lack access to dental care. While there are clinically proven techniques to prevent or delay the progression of dental health problems (according to the U.S. Surgeon General's report, Oral Health in America), an estimated 25 million Americans live in areas lacking adequate dental services.

The Health Care Safety Net Amendments of 2001 therefore contain a number of provisions to strengthen the oral health care safety net by increasing the dental workforce in our Nation's rural and underserved communities. Among other provisions, it directs the Secretary to develop and implement a plan for increasing the participation of dentists in the National Health Service Corps scholarship and loan repayment program. It also improves the process for designating dental health professional shortage areas and ensures that the criteria for making such designations provides a more accurate reflection of oral health need, particularly in rural areas. Finally, it authorizes $50 million over 5 years for grants to States to help them develop innovative dental workforce development programs specific to their individual needs to improve access to oral health services in designated dental health professional shortage areas. This program would be administered by the Health Resources and Services Administration of the Department of Health and Human Services. States receiving Federal funds under this program would have to match at least 40 percent of the grant amount.

Currently, the Corps requires dental schools to sign an Educational Partnership Agreement, which in turn provides students attending such schools eligibility to compete for the NHSC Scholarship Program. The committee urges the Corps to discontinue the Educational Partnership Agreement.

The NHSC should work with dental education institutions, dental organizations, and State and local public health departments to determine dental site readiness, especially in rural and border areas. There are many examples of collaborative efforts between dental schools, dental organizations, community health centers, and State and local health departments that can be expanded via the involvement of NHSC participants.

In its 1994 Appropriations Conference Report, Congress directed the NHSC to undertake an "oral health initiative." NHSC made a one-time expenditure of $600,000, which developed nine new dental sites. The American Dental Education Association and the American Dental Association were encouraged that the new sites helped to increase oral health care delivery to underserved areas and recruitment of additional dentists, as well as an increased number of available sites to place oral health practitioners. This "oral health initiative" should be continually evaluated to determine the level of need for further site development in health professional shortage areas and the appropriate level of funding.

Mental and behavioral health

The committee recognizes that the NHSC is meeting only 6 percent of the requests from more than 700 Mental (and Behavioral) Health Professional Shortage Areas. In fact, many more underserved communities need mental and behavioral health profes-

sionals but have not yet obtained the designation because attention to mental and behavioral health needs of the underserved is just beginning. Approximately 25 percent of people in the United States live in rural communities, and approximately 55 percent of those rural residents have no access to mental and behavioral health services. The role of mental and behavioral health professionals is to complement and supplement the work of the physical and oral health professionals.

The committee believes that mental and behavioral health professionals are essential to an effective, integrated, and seamless system of primary health care provided to underserved communities, and they should be afforded the opportunity to participate in both the National Health Service Corps Scholarship and Loan Repayment Programs.

Locum tenens

The committee appreciated previous efforts to provide for temporary relief of health care providers through a locum tenens program within the National Health Service Corps. The temporary relief not only assists with retention by reducing clinician burnout, but also allows clinicians to attend professional meetings and gain up-to-date information about health care delivery. Therefore, we strongly urge that the Secretary to re-institute this program and continue to encourage health professionals who are not part of the National Health Service Corps to be a part of this program.

One percent set aside

The committee is concerned that the health care safety net programs are not being properly evaluated, even though 1 percent of the total appropriations are allocated for evaluation, according to Section 301 of the Public Health Service Act. Because the committee values these programs, we hope that efforts will be made to more thoroughly evaluate the effectiveness and efficiencies of these vital programs. In particular, the committee is heartened by the Administration's hard work to redefine the health professional shortage areas, and we hope that this work will continue until appropriate regulations are in place.

Further, the committee also requests that no later than 6 months after the date of the enactment of the Health Care Safety Net Amendments of 2001, the Secretary commence a study of the existing primary, oral, and mental and behavioral health care delivery systems in health professional shortage areas. The purpose of this study would be to identify the unmet health care needs of the underserved communities, including rural areas, the vulnerable populations living in health professional shortage areas, and the manner in which such needs may be met. Furthermore, after this study has been conducted, we request that the Secretary prepare a report that includes the findings of this study and makes recommendations for programmatic policy changes in the National Health Service Corps deemed most appropriate to the unique requirements of these communities and their diverse populations, as well as those most effective in eliminating the identified need for additional health care services in health professional shortages areas.

Chiropractic/pharmacist demonstration project

Section 317 of the bill authorizes the establishment of a demonstration project to provide for the participation of doctors of Chiropractic and Pharmacists in the Loan Repayment Program contained in section 338B of the bill.

It is the intent of the committee in approving this demonstration project that participation be broad-based and comprehensive, and that the Secretary ensure that the scope of the demonstration project reaches to all regions of the country. However, it is up to individual communities to decide if they would like to participate in the demonstration project. Furthermore, the committee intends that the Secretary shall include a substantial number of representatives from the major chiropractic health professions organizations, including the Association of Chiropractic Colleges and the American Chiropractic Association; and from the major pharmacist professional organizations, including the American Association of Colleges of Pharmacy and other appropriate pharmacy groups, in providing input, advice, and counsel to the Secretary and his staff regarding the development, implementation, and oversight of the demonstration project.

In evaluating the demonstration project for chiropractors and pharmacists, the appropriate number of clinicians to be included within the demonstration should include a sufficient number to determine the effectiveness of the program, taking into account the relative unmet needs in the health professional shortage areas documenting physical, oral, or mental and behavioral health needs.

In addition to the reports required under this section, the committee expects to receive periodic written reports, describing in detail the development and implementation of this section, including the input provided from the chiropractic and pharmacists groups referenced in this report.

HEALTHY COMMUNITIES ACCESS PROGRAM

The committee bill establishes a new Health Communities Access Program (HCAP) in Section 340 of the Public Health Service Act. HCAP is designed as a grant program established for the purpose of improving access to health services for the uninsured and underinsured through better integration of health services within communities.

Safety net infrastructure needs vary from community to community, and a Federally directed solution should be flexible enough to address the varying needs of each community. The committee recognizes that reality, and hopes HCAP will allow communities to propose innovative solutions tailored to their unique solutions.

Participation of core safety net providers in HCAP consortia

The committee wants to ensure that the relatively small amount of Federal HCAP grant funding is allocated in the most effective manner possible so that it can reach the maximum number of uninsured and underserved individuals. For this reason, the committee bill establishes a requirement that any HCAP consortium include the four main groups in a community, if they exist within that community, that provide health services to the uninsured and underserved: community health centers, private health care pro-

viders, hospitals with LIURs of 25 percent or more, and public health departments.

All four groups must participate in a consortium to be eligible for a grant, unless one of the groups does not exist in the community, declines or refuses to participate, or places unreasonable conditions on their participation. By involving all of these groups equally in the makeup of the consortium, it is the committee's intent that the members of a consortium work cooperatively to coordinate health care services across a community and improve access to those services. The committee expressly encourages consortiums to be inclusive in representing interested organizations within the consortium.

The committee does not intend to designate any specific organization or entity as a priority recipient of HCAP grant funds. The committee hopes this legislation will encourage a variety of innovative models for integrating health services for the uninsured. Public and nonprofit providers are encouraged to apply cooperatively as eligible entities, and according to the will of the community.

It is the intent of the committee that each of the four aforementioned provider groups be represented in a community's decision-making structure. Hopefully, this will strike a balance between providing communities flexibility in organizing their decision-making processes for the consortium and ensuring fair representation of all the provider groups involved in the consortium. The committee in no way intends to undercut the critical role played by all safety net providers in a community—both public and nonprofit—in providing integrated care to the uninsured and underserved.

The committee believes that this program's success will in part be measured on its ability to encourage widespread participation among community providers of health care. The new HCAP program is an important step in assisting communities as they innovate to improve access to health care services for underserved populations.

Fifteen percent direct services limitation

The committee bill limits the use of HCAP funding for direct patient care and services to no more than 15 percent of each grant. This program is intended to provide support for the development of the infrastructure necessary to support integration among safety net providers of care to the uninsured. It is not intended to primarily support the care itself, as successful Federal programs such as community health centers, Ryan White, maternal and child health, and others have been established to provide direct services. These other sources of funding, however, are targeted to particular types of providers or particular types of treatment. Without HCAP, no Federal program provides assistance that cuts across these targeted programs to ensure integration among providers. For example, HCAP can be used to connect direct care providers by getting specialty and hospital care for uninsured patients of community health center and Ryan White providers. The committee believes that HCAP funding can have the greatest impact on local integration if it is used as seed funding for infrastructure to enable the coordination of care to the uninsured.

Continuation funding for CAP grantees

As noted above, HCAP is based on the Community Access Program (CAP) demonstration project that was launched in FY 2000. Seventy-six communities have received funding through CAP, and the committee understands that approximately 50 more communities will be awarded grants before the end of FY 2001. Because of the exciting early results from these experiments of community integration, the committee believes that these initiatives should be supported and continued. For that reason, the committee voted to authorize HCAP at $125 million for FY 2002. Although the ultimate goal of the program is for local programs to be self-sustaining, the committee recognizes that 1-year Federal funding, in most cases, is insufficient to accomplish the intended purposes of the grant. Therefore, the committee supports the use of a portion of the appropriations provided for HCAP to award continuation funding for FY 2000 and FY 2001 CAP grantees.

Leveraging local support through HCAP grants

Through current models for HCAP, communities have been successful in leveraging local support to complement the initial Federal investment. In fact, the CAP demonstration project requires that applicants demonstrate sustainability. Many coalition partners in CAP collaborative groups have provided resources to support their efforts—some through matching donations and others through in-kind contributions. The Secretary should encourage all of these approaches and efforts—both to enhance current Federal support and to sustain programs once such support expires.

Computer decision support services

The committee is supportive of the inclusion of computer decision support services in the provision of coordinated health care within HCAP. Computer decision support services assist the clinician in applying new information to patient care through the analysis of patient-specific clinical variables. Many of these systems are used to enhance diagnostic efforts and provide extensive differential diagnoses based on clinical information entered by the clinician. Other forms of clinical decision support systems, including antibiotic management programs and anticoagulation dosing calculators, seek to prevent medical errors and improve patient safety.

RURAL HEALTH CLINICS

The Rural Health Clinics (RHC) program was authorized by Public Law 95–210. Currently, more than 3,000 Federally certified Rural Health Clinics are located throughout the United States. These clinics are primary care facilities located in rural communities that are designated as a medically underserved area, health professional shortage area, or underserved area designated by the State's governor. RHCs utilize a team approach to health care delivery. Every clinic must be staffed by at least one physician—full-time or part-time—who serves as the clinic's medical director, at least one physician assistant, nurse practitioner, or nurse midwife.

By virtue of being an RHC, these facilities received special Medicare and Medicaid payments. However, unlike Federally qualified

health centers, RHCs receive no Federal payments to care for uninsured or underinsured.

The committee believes that RHCs and the providers that work in these facilities are an integral part of the rural health care safety net. However, barriers exist that inhibit the ability of RHCs to deliver care to uninsured or underinsured individuals in their service areas. They also realize barriers to maintaining adequate amounts of staff for the provision of these services. Therefore, the committee has opted to provide certain exceptions to RHCs if they are willing to otherwise comply with the requirements of section 334.

Current Federal law waives the Medicare deductible when individuals eligible for Medicare obtain that care at a Federally qualified health center. No similar waiver is in place when a Medicare beneficiary obtains care at a Rural Health Clinic. The committee believes that a similar waiver should exist for low-income Medicare beneficiaries when they obtain care at a Federally certified Rural Health Clinic that is otherwise eligible for Corps placement. Therefore, the committee has included language that would waive the Medicare deductible for individuals who qualify for subsidized services under the Public Health Services Act for those clinics. Therefore, low-income Medicare beneficiaries living in rural underserved areas served by Rural Health Clinics otherwise eligible for placement of a Corps member would have the same ability to obtain health care as low-income Medicare beneficiaries living in areas served by Federally qualified health centers.

The committee also is proposing to clarify the language regarding the ability of Rural Health Clinics to offer a sliding fee scale for low-income beneficiaries if they would otherwise be eligible for placement of a Corps member. Under current law, health care providers are prohibited from offering a cash inducement to individuals to encourage that individual to obtain health care under a Federal health care program. This is commonly referred to as the "anti-kickback" statute. Many RHCs have expressed concern that this means that clinics cannot offer a sliding fee scale for their low-income patients under one of the requirements of section 334.

The law does provide a safe harbor for Federally qualified health centers that waive the coinsurance for low-income Medicare beneficiaries. The committee would extend that waiver authority to Rural Health Clinics so that clinics would not be in violation of the anti-kickback statute if the clinic waived the Medicare co-pay for individuals who qualify for subsidized services under the Public Health Service Act. As with the deductible provision, this would insure that low-income individuals residing in rural areas served by Rural Health Clinics who would otherwise be eligible for Corps placement could have the same opportunities to get the Medicare co-pay waived, as would low-income individuals residing in areas served by Federally qualified health centers.

The committee does not intend to amend the Social Security Act for all RHCs, but only for those who are willing to comply with Section 334 of the Public Health Service Act and who would otherwise be eligible for Corps placement (i.e., be located in a HPSA).

V. COST ESTIMATE

Due to time constraints, the Congressional Budget Office estimate was not included in the report. When received by the committee, it will appear in the Congressional Record at a later time.

VI. APPLICATION OF LAW TO THE LEGISLATIVE BRANCH

The Health Care Safety Net Amendments of 2001 reauthorizes and amends the Public Health Service Act to strengthen the health care centers program, continue the National Health Service Corps, improve and expand rural programs, and establish the Health Communities Access Program under the newly created Section 340 of the Public Health Service Act. As such, the committee finds that the legislation has no application to the legislative branch.

VII. REGULATORY IMPACT STATEMENT

The committee has determined that there will be minimal increase in the regulatory burden as a direct result of this bill. This legislation will increase access to medical services in underserved areas through the strengthening of Health Centers programs, the reauthorization of the National Health Service Corps, and the expansion of rural health programs. Also, the implementation of the Healthy Communities Access Program will provide for a more effective and coordinated use of community resources in providing health services to the uninsured and underserved.

VIII. SECTION-BY-SECTION ANALYSIS

Note on References: Except as otherwise specified, as used in the summary—

"The Act" means the Public Health Service (PHS) Act, and references to provisions of law are provisions of the PHS Act;

"Corps" means the National Health Service Corps;

"Health centers" means the Consolidated Health Centers, which includes community health centers, migratory health centers, health centers for the homeless, and public housing health centers; and

"Secretary" means the Secretary of Health and Human Services.

Section 1. Short Title; Table of Contents.

Section 1(a) cites this Act as the "Health Care Safety Net Amendments of 2001."

Section 1(b) sets forth the table of contents for this Act.

TITLE I—CONSOLIDATED HEALTH CENTER PROGRAM AMENDMENTS

Section 101, Health Centers, includes various amendments to the Consolidated Health Centers Program, Section 330 of the PHS Act.

Section 330(b)(1) is amended to change the requirement for health centers to provide screening for breast and cervical cancer to a requirement to provide appropriate cancer screening. When making referrals to providers of medical services, health centers are required to provide specialty referrals when medically indicated. Health centers are required to assist patients in establishing

eligibility for and gaining access to Federal, State, and local programs that provide or financially support housing services.

Section 330(b)(2) is amended to include as additional environmental health services that may be provided by a health center: (1) the detection and alleviation of chemical and pesticide exposures; (2) the promotion of indoor and outdoor air quality; and (3) the detection and remediation of lead exposures.

Section 330(b)(2) is amended to include behavioral and mental health and substance abuse services as well as recuperative care services and public health care services as additional services which may be provided by health centers as appropriate to meet the needs of the population served by the center.

Section 330(c)(1)(A) is amended to allow health centers to use funds for planning grants to lease, modernize, and expand existing buildings, construct new buildings, and purchase and lease equipment (including the costs of amortizing the principal of, and paying the interest on, loans for buildings and equipment).

Section 330(c)(1)(B) is amended to change the name of the section from "Comprehensive Service Delivery Networks and Plans" to "Managed Care Networks and Plans."

A new section 330(c)(1)(C) allows the Secretary to make grants to a new category of networks—practice management networks, networks which will enable the centers to reduce costs, improve access to and the availability of health care services, enhance the quality and coordination of health care services, or improve the health status of communities. For these networks, health centers may use funds to purchase or lease equipment, which may include data and information systems, to provide training and technical assistance related to the provision of health services on a prepaid basis, and to develop practice management or managed care networks or plans.

Section 330(d)(1) is amended to change the name of the "Managed Care Loan Guarantee Program" to the "Loan Guarantee Program". Section 330(d)(1)(A) is amended to provide a guarantee for up to 90% of the principal and interest on loans made by non-Federal lenders to health centers for the costs of the managed care and practice management networks, including the costs of acquiring, leasing, or modernizing existing buildings, constructing new buildings or purchasing or leasing equipment.

Section 330(d)(1)(B) is amended to allow funds to be used for the refinancing of existing loans, provided that the Secretary determines that the financing will result in more favorable terms and will be beneficial to both the health center and the government.

Section 330(d)(1) is further amended by adding a subsection (D) to allow funds appropriated under fiscal years 1997 and 1998 for the loan guarantee program to be available until expended.

Section 330(d)(1) is further amended to add a new subsection (E) to allow guarantees to be made directly to managed care plans or networks if the health center requests and if the networks or plans are at least majority owned and/or majority controlled (as applicable) by the health centers.

Section 330(d)(1) is amended by adding a subsection (F) to apply the requirement of the Federal Credit Reform Act to refinanced loans.

Section 330(e)(1) is amended by adding a new subsection (C) to allow the Secretary to make operating grants directly to managed care plans and networks if the health center requests and if the networks or plans are at least majority owned and/or majority controlled (as applicable) by the health centers. Operating grants may be used for acquiring, leasing, modernizing, and expanding buildings, constructing buildings, and purchasing or leasing equipment (including the costs of amortizing principal and paying interest on loans for buildings and equipment), and training.

Section 330(e)(4)(B) limits the amount of operating grants that can be allocated to the managed care networks or plans to not more than 2 percent the total amount appropriated for these grants in a fiscal year.

Section 330(g) is amended to clarify that grants are available to assist with environmental services for seasonal agricultural workers.

Section 330(h)(4) is amended to include homeless youth as eligible populations to be served under the Consolidated Health Centers Program. This subsection is further amended to provide that homeless centers can continue to provide services for up to 12 months after an individual is no longer homeless. This subsection is also amended to include risk reduction, outpatient treatment and rehabilitation as appropriate substance abuse services.

Redesignated section 330(l) is amended to require centers to have contracts with the State agency administering the State Children's Health Insurance Program (in addition to Medicaid) for payment of the costs of services provided to persons eligible under that program. This redesignated subsection is further amended to require that centers assure that no patient will be denied health services due to an individual's inability to pay for such services and will assure that any fees or payments required by the center will be reduced or waived for such situations. A health center's governing board is required to review any internal outreach plans for specific subpopulations served by the center.

A new section 330(j) is added to authorize the Secretary to make grants to health centers to identify and detect environmental factors and conditions and to provide services to reduce the disease burden related to environmental factors and exposure of populations to such factors, and alleviate environmental conditions that affect the health of individuals and communities served by health centers.

A new section 330(k) is added to authorize the Secretary to award linguistic access grants to eligible health centers to provide translation, interpretation, and other such services for clients with limited English speaking sufficiency. Appropriations are authorized for such grants in the amount of $10 million for FY 2002 and such sums as may be necessary for each of the fiscal years 2003 through 2006.

Redesignated section 330(s) is amended to add a requirement that in the case of a project involving the modernization of a building that the application contain reasonable assurances that the prevailing rate in the locality be paid to all laborers and contractors on the project in accordance with the Davis-Bacon Act.

Redesignated section 330(m) is rewritten to require the Secretary to establish a program to provide technical and other assistance to

health centers. Services may include necessary technical and non-financial assistance, including fiscal and program management assistance, training in fiscal and program management, operational and administrative support, and the provision of information to the entities on available resources and how those resources can best meet the community health needs.

Redesignated section 330(t) is amended to authorize, for the Consolidated Health Centers Program, appropriations of $1.369 billion for fiscal year 2002 and such sums as necessary for fiscal years 2003 through 2006. In awarding grants, the Secretary, for FY 2002 and each of the following fiscal years, must ensure that the proportion of total amounts made available to health centers for migrants, homeless, and public housing residents is equal to the proportions made available for these groups in FY 2001. Funds for building construction, expansion or renovation are restricted to not more than 5 percent of the total amount of funds appropriated in a year.

TITLE II—RURAL HEALTH

Subtitle A—Rural Health Care Services Outreach, Rural Health Network Development, and Small Health Care Provider Quality Improvement Grant Programs

Section 201, Grant Programs, amends Section 330A of the Act to specifically separate the rural health grants from the telehealth grants and to create a small health care provider quality improvement grant program.

New sections 330A (a) through (d) describe the purpose of program, define terms, and outline general administration of the program. Under this program, grants would be available for expanded delivery of health care services in rural areas, for the planning and implementation of integrated health care networks in rural areas, and for planning and implementation of small health care provider quality improvement activities. The program would be administered by the Director of the Office of the Office of Rural Health Policy of the Health Resources and Services Administration (HRSA).

Section 330A(e) authorizes the Director of the Office of Rural Health Policy of HRSA to award grants to eligible entities to promote rural health care services outreach by expanding the delivery of health care services to include new and enhanced services in rural areas. The grants may be awarded for periods of not more than 3 years. Eligible grantees must be a rural public or rural nonprofit private entity and represent a consortium of 3 or more health care providers.

Section 330A(f) authorizes the Director to award rural health network development grants to eligible entities to promote, through planning and implementation, the development of integrated health care networks that have combined the functions of network entities in order to achieve efficiencies, expand access, and to strengthen the rural health care system as a whole. Grants for implementation activities may be awarded for 3–year periods and grants for planning activities may be awarded for one-year periods. Eligible grantees must be a rural public or rural nonprofit private entity and represent a consortium of 3 or more health care providers.

Section 330A(g) authorizes the Director to award grants to eligible entities to provide for the planning and implementation of small health care provider quality improvement activities. Grants are limited to periods of 1 to 3 years. The Director must award not less than 50 percent of available funds to providers located in and serving rural areas. Eligible grantees must be a rural public or rural nonprofit private health care provider or provider of health care services, such as a rural health clinic or another rural provider or network of small rural providers identified by the Secretary as a key source of local care.

Section 330A(h) prohibits rural health grant monies from being used to build or acquire real property, or for construction (other than for minor renovations relating to the installation of equipment). The Secretary must coordinate with similar grant programs to maximize the effect of public dollars. Preference must be given to applicants that: (1) are located in health professional shortage areas or medically underserved communities, or serve medically underserved populations; or (2) propose to develop projects with a focus on primary care, and wellness and prevention strategies.

Section 330A(i) requires the Secretary to report to the appropriate congressional committees, not later than September 30, 2005, on the progress and accomplishments of the grant programs.

Section 330A(j) authorizes for these rural health grants appropriations of $40 million for FY2002 and such sums as necessary for each of the fiscal years 2003 through 2006.

Subtitle B—Telehealth Grant Consolidation

Section 211 cites this subtitle as the "Telehealth Grant Consolidation Act of 2001".

Section 212 amends the Act to add new section 330I to establish telehealth network and telehealth resource centers grant programs. (Similar authority exists in current law, section 330A.)

New sections 330I(a) through (c) define terms and outline administration of the program. An Office for the Advancement of Telehealth, headed by a Director would be established in HRSA. The Secretary would be required to establish telehealth network and telehealth resource centers grants programs.

Section 330I(d)(1) authorizes the Director to make telehealth network grants to eligible entities for projects to demonstrate how telehealth technologies can be used through telehealth networks in rural areas, frontier communities, and medically underserved areas, and for medically underserved populations, to: (1) expand access to, coordinate, and improve the quality of health services; (2) improve and expand the training of health care providers; and (3) expand and improve the quality of health information.

Section 330I(d)(2) authorizes the Director to award grants to eligible entities for projects to demonstrate how telehealth technologies can be used in the above-mentioned areas to establish telehealth resource centers.

Section 330I(e) limits both grants to periods of not more than 4 years.

Section 330I(f) defines an eligible grantee as a nonprofit entity. Grantees for telehealth networks must also provide services through a network of at least two entities, one of which must be a community-based provider.

Section 330I(g) specifies requirements for applications.

Section 330I(h) specifies terms and conditions of grants.

Section 330I(i) specifies that the Secretary must give preference to an entity that meets one of the requirements specified for organization, services, coordination, network, connectivitity, and integration. The Secretary must give preference to telehealth resource center grantees that meet at least one of the requirements specified for: success in the provision of services, a record of collaborating and sharing expertise, and a record of providing a broad range of telehealth services.

Section 330I(j) requires the Director to ensure that grants are equitably distributed among the geographical regions of the U.S. The Director must also ensure that not less than 50 percent of grant awards are made to projects in rural areas and that the total amount for such projects are not less than the total amount awarded for such projects under existing 330A in FY2001.

Section 330I(k) specifies that grants may be used for salaries, equipment, and operating or other costs such as education.

Section 330I(l) specifies uses for which grants may not be used, including acquiring real property, for purchase or lease of equipment to the extent such expenditures would exceed 40 percent of total grant funds, and certain other equipment.

Section 330I(m) requires that grantees collaborate with other telehealth entities that receive Federal or State assistance.

Section 330I(n) requires the Director to coordinate with similar grant programs to maximize the effect of public dollars.

Section 330I(o) requires the Secretary to carry out outreach activities on the grant programs.

Section 330I(p) expresses the sense of the Congress that States should develop reciprocity agreements so that licensed telehealth providers can conduct consultations under the various State laws.

Section 330I(q) requires the Secretary to report to the appropriate congressional committees, not later than September 30, 2005, on the progress and accomplishments of the grant programs.

Section 330I(r) requires the Secretary to issue regulations that define frontier area, based on factors that include population density, travel distance and travel time to the nearest medical facility, and other factors as appropriate.

Section 330I(s) authorizes appropriations of: (1) $40 million for telehealth network grants for FY2002 and such sums as necessary for each of the fiscal years 2003 through 2006; and (2) $20 million for telehealth resource center grants for FY2002 and such sums as necessary for each of the fiscal years 2003 through 2006.

Section 212 adds a new section 330J to authorize the Secretary to establish and carry out telehomecare demonstration projects.

New section 330J(a) and (b) define terms and require the Secretary, not later than 9 months after enactment, to establish a telehomecare demonstration project.

Section 330J(c) requires the Secretary to make not more than five grants to eligible certified home care providers, individually or as part of a network of home health agencies, for the provision of telehomecare to improve patient care, prevent heath care complications, improve patient outcomes, and achieve efficiencies in the delivery of care to patients who reside in rural areas.

Section 330J(d) requires that grants be limited to periods of 3 years.

Section 330J(e) requires that grant applications contain information as specified by the Secretary.

Section 330J(f) provides that the funds must be used for objectives that include: (1) improving access to care for home care patients served by home health care agencies, improving quality and patient satisfaction, and reducing costs through direct telecommunications with information networks; (2) developing effective care management practices and training for home care registered nurses; and (3) developing training curricula for health care professionals, particularly registered nurses, serving home care agencies in the use of telecommunications.

Section 330J(g) specifies that this section should not be construed as superseding or modifying Medicare law.

Section 330J(h) requires the Secretary, not later than 6 months after the last grant period, to report to Congress on results from the demonstration project.

Section 330J(i) authorizes for this section appropriations of such sums as necessary for each of fiscal years 2002 through 2006.

Subtitle C—Mental Health Services Telehealth Program and Rural Emergency Medical Service Training and Equipment Assistance Program

Section 221 adds new section 330K, Rural Emergency Medical Service Training and Equipment Assistance Program.

New section 330K(a) requires the Secretary to award grants to eligible entities to provide improved emergency medical services in rural areas.

Section 330K(b) requires that eligible grantees be a State emergency medical office, a State emergency medical services association, a State office of rural health, a local government entity, a State or local ambulance provider, or any other entity determined appropriate by the Secretary.

Section 330K(c) requires that grant funds be used for emergency medical service squads that are located in, or that serve residents of, a nonmetropolitan statistical area, an area designated as a rural area, or a rural census tract of a metropolitan statistical area to recruit and train personnel, acquire emergency medical services equipment, and educate the public on emergency preparedness topics.

Section 330K(d) requires that the Secretary, in awarding grants, give preference to applications that reflect a collaborative effort by 2 or more specified entities and that intend to use funds for certain activities.

Section 330K(e) requires grantees to contribute from other public or private sources an amount equal to 25% of the Federal grant.

Section 330K(f) states that emergency medical services: (1) means resources used by qualified public or private nonprofit entities to deliver medical care outside of a medical facility under emergency conditions that occur as a result of the patient's condition or as a result of a natural disaster or similar situation; and (2) includes services delivered by compensated or volunteer providers, licensed or certified providers recognized by the State involved, a registered nurse, a physician assistant, or a physician

that provides services similar to those provided by such an emergency medical services provider.

Section 330K(g) authorizes appropriations of such sums as may be necessary for each of the fiscal years 2002 through 2006 for these grants. The Secretary may not use more than 10% of appropriations for any year for administrative expenses for carrying out this program.

Section 221 adds new section 330L concerning mental health services delivered via telehealth.

New section 330L(a) and (b) define terms and require the Secretary, acting through the Director of the Office for the Advancement of Telehealth, to award grants to eligible entities for demonstration projects to provide mental health services to special populations as delivered remotely by qualified mental health professionals using telehealth and for the provision of education regarding mental illness as delivered remotely by qualified mental health professionals and qualified mental health education professionals using telehealth.

Section 330L(c) provides that each grant recipient must receive not less than $1,200,000 under the grant and cannot use more than 40 percent of grant funds for equipment.

Section 330L(d) requires that grants be used to provide mental health services, education, and collaboration with local public health authorities. Grants may also be used for equipment, and other enumerated purposes.

Section 330L(e) requires the Secretary to ensure that grants are equitably distributed among all regions of the U.S.

Section 330L(f) requires that applications for grants conform to information specified by the Secretary.

Section 330L(g) requires a report to the appropriate congressional committees, not later than 4 years after the date of enactment of this Act, on an evaluation of grant activities.

Section 330L(h) authorizes appropriations of $20 million for FY2002 and such sums as may be necessary for fiscal years 2003 through 2006 for these grants.

Subtitle D—School-Based Health Center Networks

Section 231 adds to the Act new section 330M concerning school-based health center networks.

New section 330M(a) defines an eligible entity as a nonprofit organization that has experience working with low-income communities, schools, families, and school-based health centers.

Section 330M(b) and (c) require the Secretary to award grants for the establishment of statewide technical assistance centers to coordinate local, State, and Federal health care services that contribute to the delivery of school-based health care for medically underserved individuals and to conduct other support activities for school-based health center networks, to maximize operational effectiveness and efficiency and to provide technical support training.

Section 330M(d) requires applications to contain information specified by the Secretary.

Section 330M(e) authorizes appropriations of $5 million for FY2002 and such sums as necessary for subsequent fiscal years.

TITLE III—NATIONAL HEALTH SERVICE CORPS PROGRAM

SECTION 301. NATIONAL HEALTH SERVICE CORPS (CORPS)

Section 301(a) amends Section 331(a) of the Act to define "behavioral and mental health professionals" as health service psychologists, licensed clinical social workers, licensed professional counselors, marriage and family therapists, psychiatric nurse specialists, and psychiatrists.

Section 331(a) of the Act is further amended to define "graduate program of behavioral and mental health" as a program that trains behavioral and mental health professionals.

Section 331(b) of the Act is revised to include schools at which graduate programs of behavioral and mental health are offered as among those at which the Secretary may conduct recruiting programs for the Corps, Scholarship Program and the Loan Repayment Program.

Section 331(b) is further revised to include behavioral and mental health professionals, among those who may participate in fellowship programs to enable them to gain exposure to and expertise in the delivery of primary health services in health professional shortage areas.

Section 331(c) is revised to allow the Secretary to reimburse an applicant for actual and reasonable expenses incurred for the travel of one family member to accompany the applicant to visit an eligible site to which the applicant may be assigned (in addition to travel expenses for the applicant himself/herself). If an individual enters into a contract for obligated service under the Scholarship Program or the Loan Repayment Program, the Secretary may reimburse the individual for all or part of actual and reasonable expenses incurred in relocating the individual and the individual's family to the eligible site. The Secretary may to establish a maximum total amount that an individual may be reimbursed for relocation expenses.

Section 301(b) adds a new section 331(i) in which the Secretary is authorized to carry out demonstration projects so that individuals who are obligated to a period of service under the Loan Repayment Program may receive waivers to satisfy the requirement for providing clinical service at a selected entity on a less than full-time basis. Waivers could be provided only under certain conditions, including requirements that the Secretary determine that less than full-time service would be appropriate for the area, that service be for no less than 16 hours per week, and that the period of obligated service be extended so that total time of service would be equal to full-time. In evaluating a demonstration project in which Corps members satisfy requirement for obligated service through less than full-time service the Secretary would be required to examine the effect of multidisciplinary teams.

SECTION 302. DESIGNATION OF HEALTH PROFESSIONAL SHORTAGE AREAS

Section 302(a) amends section 332(a) (dealing with the designation of Health Professional Shortage Areas) to require that all Federally qualified health centers and rural health clinics (as defined in Medicare law) that meet cost-sharing requirements for the Corps be automatically designated as having a health professional short-

age. Not later than 5 years after the date of enactment of this Act, and every 5 years thereafter, each such health center or rural health clinic is required to demonstrate that it meets the requirements for designation as specified in Federal regulations.

Section 332(a) is further amended to include in the list of populations that the Secretary may designate as a health manpower shortage area, seasonal agricultural workers and migratory agricultural workers and residents of public housing.

Section 332(b) is amended to repeal as requirements for the Secretary's special consideration in designating health professional shortage areas the following explicit indicators of need: infant mortality, access to health services, health status, and ability to pay for health services.

Section 332(c)(2)(B) is amended to add a requirement that the Secretary, when determining whether to designate a health professional shortage area, consider the extent to which a population that is entitled to have payment made for services under the State Children's Health Insurance Program (S–CHIP), in addition to Medicare and Medicaid, cannot obtain such services because of suspension of physicians under this program.

Section 302(b) requires the Secretary to report to the House Energy and Commerce and Senate Health, Education, Labor, and Pensions Committees if the Secretary issues a regulation that revises the definition of a health professional shortage area or the standards for prioritizing areas that receive assignments of Corps personnel.

Section 302(c) requires the Secretary, in consultation with specific health professionals and public health officials, to develop and implement a plan to increase the level of participation by dentists and dental hygienists in the Scholarship Program and the Loan Repayment Program.

Section 302(d) directs the Administrator of HRSA, to revise criteria for designating dental health professional shortage areas, in consultation with specific health professional groups and public health officials in order to provide a more accurate reflection of oral health care needs, particularly in rural areas.

Section 302(d) adds a new section 332(i) to require the Administrator of HRSA to disseminate information about the designation criteria to the Governor of each State; the representative of any area, population group or facility selected by a Governor to receive such information; the representative of any area, population group or facility that requests such information; and the representative of any area, population group, or facility determined by the Administrator as likely to meet the criteria for designation.

SECTION 303. ASSIGNMENT OF CORPS PERSONNEL

Section 303 amends Section 333(a)(1) of the Act to authorize the Secretary to assign Corps members to any public or private entity. (Currently, Corps members are assigned to only public and nonprofit private entities.)

Section 333(a)(3) adds a requirement that, in approving applications for assignments of Corps members, the Secretary must give preference to nonprofit or public entities that will provide a site to which Corps members may be assigned.

Section 333(d)(1) of the Act is revised to specifically require (rather than allow) the Secretary to provide technical assistance to entities that are located in health professional shortage areas and desire to apply for the assignment of a Corps member.

Section 333(d)(1) is further amended by adding a new provision to authorize the Secretary to provide assistance to an entity for developing long-term plans for addressing health professional shortages and improving access to health care. The section is also amended to require the Secretary to encourage those entities receiving technical assistance to communicate with other communities and public health groups concerned with site development and community needs assessment.

SECTION 304. PRIORITIES IN ASSIGNMENT OF CORPS PERSONNEL

Section 304 amends Section 333A of the Act to repeal requirements that the Secretary consider only certain factors for determining priority assignments of Corps personnel to health professional shortage areas with the greatest shortages.

Section 333A(d) is revised to require the Secretary to prepare and publish a proposed list of health professional shortage areas and entities that would receive priority for the assignment of Corps members. In addition to existing requirements for information to be included in the list, the list must contain relative scores and relative priorities of the entities submitting applications for the assignment of Corps members. The Secretary must give all entities 30 days after the date of publication of the list to provide additional data and information in support of being included on the list or in support of a higher priority determination, all of which the Secretary must consider in preparing the final list.

Section 333A(d) is further revised to add technical and conforming amendments related to the Secretary's notification of parties affected by the prioritization of assignments for placements of Corps members in health professional shortage areas. Entities adversely affected by revisions to the priority list would have 30 days to file a written appeal of the determination and the Secretary would be required to consider the appeal before the list becomes final.

Section 333A(e) revises current provisions with respect to the number of entities offered as assignment choices in the scholarship program. By April 1 of each year, the Secretary must determine the number of participants in the scholarship program who will be available for assignments during the program year beginning on July 1 of that calendar year. The number of entities designated to receive Corps members for the scholarship program must be no less than the number of participants available for the year, and not greater than twice the number of participants selected for the scholarship program.

SECTION 305. COST SHARING

Section 305 amends the Act to rewrite section 334 concerning charges for services by entities using Corps members.

Section 334(a) provides that entities to which a Corps member is assigned may not deny health services to individuals or discriminate in the provision of services because of inability to pay, or be-

cause payment for services would be made under Medicare, Medicaid, or SCHIP.

Section 334(b)(1) requires an entity to prepare a schedule of fees or payments consistent with locally prevailing rates or charges and designed to cover the entity's reasonable costs. Entities may also prepare a corresponding schedule of discounts, including waivers, of fees and payments. Entities must make every reasonable effort to collect from patients fees and payments for services.

Section 334(b)(2) requires an entity to accept assignments of beneficiaries under the Medicare program and enter into appropriate agreements with the State agency administering the Medicaid and SCHIP programs for payment of services under those programs. Entities must take reasonable steps to collect payments from third-party payers.

SECTION 306. ELIGIBILITY FOR FEDERAL FUNDS

Section 306 amends Section 335(e)(1)(B) of the Act to provide that any hospital found in violation of this subsection by refusing admitting privileges to a Corps member would be ineligible to receive SCHIP funds (in addition to Medicare and Medicaid funds already specified in this provision).

SECTION 307. FACILITATION OF EFFECTIVE PROVISION OF CORPS SERVICES

Section 307 amends Section 336 of the Act to change references to "health manpower shortage areas" to "health professional shortage areas".

SECTION 308. AUTHORIZATION OF APPROPRIATIONS

Section 308 amends Section 338(a)(1) of the Act to authorize such sums as necessary for appropriations for the Corps for FY2002 through FY2006. This section also repeals the requirement for the Secretary, to the extent practicable, to make assignments, other than for obligated service, of certified nurse midwives, certified nurse practitioners, or physician assistants to shortage areas.

SECTION 309. NATIONAL HEALTH SERVICE CORPS SCHOLARSHIP PROGRAM

Section 309 amends Section 338A(a)(1) of the Act to include behavioral and mental health professionals as eligible participants under the Corps Scholarship Program.

Section 338A(d)(1) is amended to require the Secretary, with respect to dental school applicants, to consider applications from all individuals accepted for enrollment or enrolled in any accredited dental school.

Section 338A(f) is amended to require an individual to agree, if pursuing a degree in medicine or osteopathic medicine, to complete a residency in a specialty that the Secretary determines is consistent with the needs of the Corps.

Section 338A(i) is repealed. The section required an annual report to the Congress on the Corps Scholarship Program.

SECTION 310. NATIONAL HEALTH SERVICE CORPS LOAN REPAYMENT PROGRAM

Section 310 amends section 338B to include behavioral and mental health professionals as eligible participants under the Corps Loan Repayment Program.

Section 338B(i) is repealed. The section requires an annual report to the Congress on the Corps Loan Repayment Program.

SECTION 311. OBLIGATED SERVICE

Section 311 amends section 338C(b) to revise provisions that specify dates when obligated service must begin for Scholarship recipients. Persons would be notified about their obligated service upon completion of training required for the degree for which the individual receives the scholarship. However, for persons receiving a degree from a school of medicine or osteopathy after September 20, 2000, service would begin when the individual completes a residency in a specialty determined by the Secretary to be consistent with the needs of the Corps. The Secretary could also defer obligated service for completion of advanced training (including an internship or residency).

Section 338C(e) is repealed. This provision allows Corps personnel to fulfill their period of obligation by working as researchers at the National Institutes of Health.

SECTION 312. PRIVATE PRACTICE

Section 312 amends section 338D to replace existing requirements for a written agreement between the Secretary and individuals who fulfill their service obligation through full-time clinical private practice. Individuals fulfilling a period of obligated service in private clinical practice must comply with requirements pertaining to cost-sharing (amounts that entities charge for services), and additional provisions as the Secretary may determine.

SECTION 313. BREACH OF SCHOLARSHIP CONTRACT OR LOAN REPAYMENT CONTRACT

Section 313 amends section 338E(a) to repeal a provision requiring individuals to repay amounts to the U.S. government for failing to accept payment or instructing the educational institution in which he is enrolled not to accept payment of a scholarship from the Corps.

Section 338E(b) is amended to authorize the Secretary to terminate a contract with an individual in the Scholarship Program if, not later than 30 days before the end of the school year, to which the contract pertains, the individual submits a written request for such termination and repays all amounts paid to or on behalf of the individual.

Section 338E(c) is amended to revise the amounts that an individual must pay when a written contract is breached in accordance with the Loan Repayment Program. The Federal Government would be entitled to recover: (1) total amounts paid on behalf of the individual; (2) an amount equal to the product of the number of months of uncompleted obligated service multiplied by $7,500; and (3) interest on these amounts at the maximum legal prevailing rate. The Secretary may terminate a contract if an individual sub-

mits a written request for such termination, and repays all amounts as required.

Section 338E(d) is revised to increase the period of years from 5 to 7 after which an obligation for payment of damages may be released as a result of a discharge of bankruptcy, depending on the decision of the bankruptcy court.

New section 338E(e) provides that, notwithstanding any other provision of law, there will be no limitation on the period within which suit may be filed, a judgment may be enforced, or an action relating to an offset or garnishment, or other action, may be initiated or taken by Federal officials for the repayment of the amount due.

SECTION 314. AUTHORIZATION OF APPROPRIATIONS

Section 314 amends section 338H(a) to authorize appropriations for the Scholarship Program of $146,250,000 for FY2002 and such sums as may be necessary for fiscal years 2003 through 2006.

Section 338H(b) requires the Secretary to obligate not less than 30 percent of amounts appropriated for scholarships to individuals who have not previously received such scholarships.

Section 338H(c) requires the Secretary to obligate not less than 10 percent of amounts appropriated for both scholarships and loan repayments for nurse practitioners, nurse midwives, or physician assistants.

SECTION 315. GRANTS TO STATES FOR LOAN REPAYMENT PROGRAMS

Section 315 amends section 338I(a) to require the National Advisory Council on the National Health Service Corps to advise the Administrator of HRSA on the program of grants to States for loan repayment programs.

Section 338I(e) is revised to require States to submit such reports to the Secretary on the loan repayment program as determined appropriate by the Secretary.

Section 338I(i) is amended to authorize appropriations of $12 million for FY2002 and such sums as may be necessary for each of fiscal years 2003 through 2006 for the grants program to States for loan repayments.

SECTION 316. DEMONSTRATION GRANTS TO STATES FOR COMMUNITY SCHOLARSHIP PROGRAMS

Section 316 repeals section 338L of the Act which authorizes demonstration grants to States for community scholarship programs to increase the availability of primary health care in urban and rural areas.

SECTION 317. DEMONSTRATION PROJECT

Section 317 adds a new section 338L to authorize the Secretary to establish a demonstration project to provide for the participation of chiropractic doctors and pharmacists in the Corps loan repayment program. The demonstration project would be required to have enough participants to properly analyze the project's effectiveness. Any providers selected to participate in the project could not be considered by the Secretary in the designation of a shortage area. States could not be required to participate. The Secretary

would be required to report to specified congressional committees on the effectiveness of the demonstration project, how the participation of chiropractic doctors and pharmacists in the loan repayment program might affect the designation of health professional shortage areas; and the feasibility of adding such individuals as permanent members of the Corps.

TITLE IV—HEALTHY COMMUNITIES ACCESS PROGRAM

Section 401 states that the purpose of this title is to provide assistance to communities and to consortia of health care providers, to develop or strengthen integrated health care delivery systems that coordinate health services for individuals who are uninsured or underinsured and to develop or strengthen activities related to providing coordinated care for such individuals with chronic conditions who are uninsured or underinsured.

Section 402 amends Part D of title III of the Act to add new Subpart V—Healthy Communities Access Program (HCAP) to establish a new section 340.

Section 340(a) authorizes the Secretary to award grants to eligible entities to assist in the development of integrated health care delivery systems to serve communities of individuals who are uninsured or who are underinsured: (1) to improve the efficiency of, and coordination among, the providers providing services; (2) to assist communities in developing programs targeted toward preventing and managing chronic diseases; and (3) to expand and enhance the services provided through such systems.

Section 340(b) outlines the eligibility requirements for a public or nonprofit private entity to receive grants. The entity must: (1) represent a consortium whose principal purpose is to provide a broad range of coordinated health care services for the community defined in the entity's grant application; (2) submit to the Secretary an application, containing specific information and other information prescribed by the Secretary, (3) agree, together with all providers within the consortium, to use grant monies awarded under this section to supplement, not supplant, any other sources of funding available to cover the expenditures (including the value of any in-kind contributions) in carrying out the activities for which the grant would be awarded; and (4) have or will establish a decision-making body that has full and complete authority to determine and oversee all consortium activities.

Section 340(c) requires that the Secretary give priority to applicants that demonstrate the extent of unmet need in the community for a more coordinated system of care. The Secretary may give priority to other applicants that best promote the objectives of this section.

Section 340(d) requires that grantees use the amounts provided under this section only for direct expenses associated with planning, developing, and operating the greater integration of a health care delivery system and direct patient care and service expansions to fill identified or documented gaps within an integrated delivery system. Not more than 15 percent of grant funds may be used for the provision of direct patient care and services. The Secretary may not use more than 3 percent of funds appropriated for the section for providing technical assistance to grantees, obtaining expert as-

sistance, the dissemination of information, evaluations, and other related administrative purposes.

Section 340(e) requires grantees to report to Secretary annually on progress in meeting the goals in the grant application and additional information as the Secretary may require, and to provide for a financial audit of grant funds. The Secretary may not renew an annual grant for any entity unless the Secretary is satisfied that the consortium represented by the entity has made progress in meeting such goals.

Section 340(f) authorizes the Secretary to provide any grantee under this section with technical and other nonfinancial assistance to meet requirements.

Section 340(g) requires the Secretary to report, not later than September 30, 2005, to the appropriate congressional committees on the progress and accomplishments of the grant program.

Section 340(h) authorizes the Secretary to make demonstration awards to historically black medical schools to: (1) develop patient-based research infrastructure at such schools with an affiliation with any providers under this section; (2) establish joint and collaborative programs of medical research and data collection between such schools and such providers; or (3) support the research-related costs of patient care, data collection, and academic training resulting from such affiliations.

Section 340(i) authorizes appropriations of $125 million for FY2002 and such sums as may be necessary for each of the fiscal years 2003 through 2006 for the program.

Section 403 amends Part D of title III of the Act to add new Subpart X—Primary Dental Programs.

New section 340F defines the term "designated dental health professional shortage area" to mean an area, population group, or facility that is designated by the Secretary as such or designated by the applicable State as having a dental health professional shortage.

New section 340G(a) authorizes the Secretary to award grants to States to help them develop and implement innovative programs to address the dental workforce needs of designated dental health professional shortage areas as appropriate to a State's needs.

Section 340G(b) lists the activities for which States may use grant funds: loan forgiveness and repayment programs for certain dentists; dental recruitment and retention efforts; assistance for dentists who participate in the Medicaid program to establish or expand practice in a designated dental health professional shortage area; establishment or expansion of dental residency programs in States without dental schools; programs to expand or establish oral health services; placement and support of dental students, dental residents, and advanced dentistry trainees; and other specified activities.

Section 340G(c) requires States to apply for grant funds in a manner as the Secretary may reasonably require and include assurances that the State will meet Federal grant-matching requirements.

Section 340G(d) requires participating States to provide matching funds in an amount equal to 40 percent of the Federal grant.

Section 340G(e) requires the Secretary to report to the appropriate congressional committees, not later than 5 years after enact-

ment of this Act, on whether such grants increased access to dental services.

Section 340G(f) authorizes appropriations of $50 million for the 5-fiscal year period beginning with FY2002.

TITLE V—RURAL HEALTH CLINICS

Section 501(a) and (b) exempt rural health clinics with Corps assignees from the coinsurance and deductible requirements of Medicare.

TITLE VI—STUDY

Section 601 requires the Secretary to study and report to the Congress on the ability of DHHS to provide for solvency of managed care networks involving health centers receiving funding under the Consolidated Health Centers Program of section 330. The report would have to be submitted to Congress 2 years after enactment.

TITLE VII—CONFORMING AMENDMENTS

Section 701(a) and (b) amend the Act to make technical and conforming amendments concerning health centers for the homeless.

IX. ADDITIONAL VIEWS

INCLUSION OF ADDITIONAL ELIGIBLE PROVIDERS IN THE NHSC

With regard to the chiropractor demonstration in the underlying bill, there were serious issues raised by the initial draft relating to both the health professional shortage area designation and the application to both the scholarship and loan repayment portions of the National Health Service Corps. The Health Resources and Services Administration (HRSA) has been working to revamp the health professional shortage designation for the past few years and is close to completion. In that alteration, Congress has pushed HRSA to count each eligible provider who is already providing services through the National Health Service Corps, rather than just counting physicians. Given that there are over 80,000 chiropractors providing care within the United States and that many of them do practice in underserved areas, the incorporation of chiropractors within the Corps; and thus, within the health professional shortage area designation, could result in many areas being de-designated. As of September 30, 1999, HRSA indicated that 12,056 physicians were needed nationwide. If chiropractors were included, we would have almost seven times the number of providers required. When I examined this issue on the state level, I determined that, even if chiropractors were only counted as half of a physician, all but four states or areas (Mississippi, Alabama, Louisiana and District of Columbia) would lose their health professional shortage area designation. Without that designation, states would not only be ineligible for the Corps, but they would also become ineligible for over 20 other programs that are tied to the HRSA designation. This change would be disasterous.

Another concern related to the role of the loan repayment and scholarship programs within the Corps program. In any demonstration program, the end result is to discover whether or not a specific initiative would be beneficial to both the community and the health care provider. In the loan repayment program, an eligible provider forms an agreement with a community regarding the provision of services. Only then the government would provide $50,000 in loan repayment (plus a 39% allocation for taxes) to the provider in exchange for two years of service. For the scholarship recipient, the eligible provider would receive a scholarship for his or her education and then would be obligated for each year in which the scholarship was given or at least two years, whichever is greater. If, at the end of the educational period, an eligible provider cannot find an appropriate community to pay his or her salary, then the provider would be in default and required to pay back three times the amount of the scholarship plus interest. Rather than potentially put a provider in a disasterous position, unable to find a community to support him or her, a Corps demonstration program

should initially focus on the loan repayment program, much like the part-time demonstration program amendment sponsored by Senators Hutchinson and Collins.

Thankfully, after an amendment was circulated which would strike the demonstration authority altogether, Senators Harkin and Reed worked together to address the aforementioned issues by specifically stating that these providers would not be counted within the health professional shortage area designation and limiting the demonstration authority to the loan repayment program. Unfortunately, the changes to the chiropractic demonstration program did not fully address all of the concerns with the program because it did not fully address my concerns relating to the spirit of the National Health Service Corps.

The National Health Service Corps was created to assist communities in addressing the primary health care needs. Its focus has been to assist communities in determining specific workforce issues and then providing incentives to health care professionals who decide to serve in those communities. We must preserve the community-centered, primary health care focus of the program. Other programs, such as Titles VII & VIII of the Public Health Service Act, are specifically tailored to address the needs of the health professional infrastructure.

During the course of two years of negotiations regarding the reauthorization of the Corps, not one community requested the inclusion of the chiropractors. Perhaps this lack of inclusion is due to the fact that chiropractors are already serving in underserved areas. Perhaps there are other reasons for not requesting these providers. Whatever the case, the focus should be upon the needs of the communities as they struggle to address their primary health care needs. Given the recent move of the Corps from the Bureau of Primary Health Care to the Bureau of Health Professionals, it is crucial that we, as Congress, recognize the specific niche of the Corps in providing resources for communities, not resources for health professionals. We have heard from numerous organizations who have voiced concerns about this move and have requested our assistance in ensuring that the Corps remains a program centered on communities that assists them in providing access to the appropriate primary care resources. We wish to send the signal that the communities and their requests should be the foremost goal of this program.

APPLICATION OF DAVIS-BACON

Legislative History.—Prior to 1988, grant funds for both planning and development of health care services for the Consolidated Health Center program could be used to support the costs of acquisition and modernization of existing buildings. At that time, Davis-Bacon provisions (40 U.S.C. § 276a—276a–7) applied only to the grants awarded to support the costs of modernization, defined in regulation as "the alteration, repair, remodeling and/or renovation of a building (including the initial equipment thereof and improvements to the building's site) which, when completed, will render the building suitable for use by the project for which the grant is made" (42 CFR 51c.502(c). However, despite the regulatory definition, the scope of modernization is typically regarded as "facility

renovations which do not modify the exterior walls of the facility" (as noted in the legislative history for the 1988 amendments).

In 1988, Section 330 of the Public Health Service Act (42 U.S.C. § 254c) was amended to permit the use of grant funds to support the costs of expansion of existing buildings and the construction of new buildings (in addition to the acquisition and modernization). However, the Davis-Bacon requirements were not expanded; they still only applied to grants to support the costs of modernization.

In 1996, under the Health Center Consolidation Act, the general authority to use grant funds to support the costs of expansion, modernization and construction was deleted (although funds could still be used to support the acquisition and lease of buildings and equipment). Grant funds may be used to support the cost of expansion, modernization and construction of projects approved pre-1996, and Davis-Bacon would apply to such projects in the same manner as pre-1996 (i.e., Davis-Bacon would apply only to grants to support the costs of modernization).

Policy Statement.—Within this re-authorization, the final policy decision was to apply the Davis-Bacon provisions to the construction authorities to which it had previously been applied prior to 1996, i.e., only to modernization of facilities. In fact, the manager's amendment that Senator Kennedy proposed, which was accepted unanimously by voice vote, did, in fact, only have the Davis-Bacon provisions applied only to modernization. Though Senator Kennedy may not be very forthcoming with that statement, the Davis-Bacon provisions were the major substantive change within the manager's amendment. Given that the committee unanimously agreed to applying Davis-Bacon only to modernization and that the previous legislative history indicates that Davis-Bacon has only previously applied to modernization, passing the bill as it was reported out of Committee would afford no disruption of labor law as it was previously applied to section 330. Any further expansion of the Davis-Bacon application would increase the difficulty in contracting for construction, modernization, and expansion, and increase the overall costs of such activities. Therefore, resources should be focused on needed health care services and not on expanding Davis-Bacon provisions.

JUDD GREGG.

X. CHANGES IN EXISTING LAW

In compliance with rule XXVI paragraph 12 of the Standing Rules of the Senate, the following provides a print of the statute or the part or section thereof to be amended or replaced (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

PUBLIC HEALTH SERVICE ACT

* * * * * * *

PART D—PRIMARY HEALTH CARE

Subpart I—Health Centers

SEC. 330. [254b] HEALTH CENTERS.

(a) DEFINITION OF HEALTH CENTER.—

* * * * * * *

(b) DEFINITIONS.—For purposes of this section:

(1) REQUIRED PRIMARY HEALTH SERVICES.—

* * * * * * *

(bb) [screening for breast and cervical cancer] *appropriate cancer screening*;

* * * * * * *

(ii) referrals to providers of medical services *(including specialty referral when medically indicated)* and other health-related services (including substance abuse and mental health services);

(iii) patient case management services (including counseling, referral, and follow-up services) and other services designed to assist health center patients in establishing eligibility for and gaining access to Federal, State, and local programs that provide or financially support the provision of medical, social *housing,* educational, or other related services;

* * * * * * *

(A) behavioral and mental health and substance abuse services;

(B) recuperative care services;

(C) public health services;

[(A)] *(D)* environmental health services, including—

(i) the detection and alleviation of unhealthful conditions associated with water supply;

(ii) sewage treatment;

(iii) solid waste disposal;

(iv) rodent and parasitic infestation;
(v) field sanitation;
(vi) housing; [and]
(vii) the detection and alleviation of chemical and pesticide exposures;
(viii) the promotion of indoor and outdoor air quality;
(ix) the detection and remediation of lead exposures; and
[(vii)] *(x)* other environmental factors related to health,

[(B)] *(F)* in the case of health centers receiving grants under subsection (g), special occupation-related health services for migratory and seasonal agricultural workers, including—

(i) screening for and control of infectious diseases, including parasitic diseases; and
(ii) injury prevention programs, including prevention of exposure to unsafe levels of agricultural chemicals including pesticides.

* * * * * * *

(c) PLANNING GRANTS.—
(1) IN GENERAL.—
(A) CENTERS.— The Secretary may make grants to public and nonprofit private entities for projects to plan and develop health centers which will serve medically underserved populations. A project for which a grant may be made under this subsection may include the cost of the acquisition [and lease of buildings and equipment (including the costs of amortizing the principal of, and paying the interest on, loans) and shall include—], *lease, modernization, and expansion of buildings, the construction of buildings, and the purchase or lease of equipment (including the costs of amortizing the principal of, and paying the interest on, loans for buildings and equipment) and shall include—*

* * * * * * *

(B) [COMPREHENSIVE SERVICE DELIVERY] *MANAGED CARE* NETWORKS AND PLANS.—The Secretary may make grants to health centers that receive assistance under this section to enable the centers to plan and develop a [network or plan for the provision of health services, which may include the provision of health services on a prepaid basis or through another managed care arrangement, to some or to all of the individuals which the centers serve.] *managed care network or plan.* Such a grant may only be made for such a center if—

* * * * * * *

[Any such grant may include the acquisition and lease of buildings and equipment which may include data and information systems (including the costs of amortizing the principal of, and paying the interest on, loans), and providing training and technical assistance related to the pro-

vision of health services on a prepaid basis or under another managed care arrangement, and for other purposes that promote the development of managed care networks and plans.]

(C) PRACTICE MANAGEMENT NETWORKS.—The Secretary may make grants to health centers that receive assistance under this section to enable the centers to plan and develop practice management networks that will enable the centers to—

(i) reduce costs associated with the provision of health care services;

(ii) improve access to, and availability of, health care services provided to individuals served by the centers;

(iii) enhance the quality and coordination of health care services; or

(iv) improve the health status of communities.

(D) USE OF FUNDS.—The activities for which a grant may be made under subparagraph (B) or (C) may include the purchase or lease of equipment, which may include data and information systems (including paying for the costs of amortizing the principal of, and paying the interest on, loans for equipment), the provision of training and technical assistance related to the provision of health care services on a prepaid basis or under another managed care arrangement, and other activities that promote the development of practice management or managed care networks and plans.

(d) [MANAGED CARE LOAN GUARANTEE PROGRAM.—] *LOAN GUARANTEE PROGRAM.—*

(1) ESTABLISHMENT.—

(A) IN GENERAL.—The Secretary shall establish a program under which the Secretary may, in accordance with this subsection and to the extent that appropriations are provided in advance for such program, guarantee [the principal and interest on loans made by non-Federal lenders to health centers funded under this section for the costs of developing and operating management care networks or plans.] *up to 90 percent of the principal and interest on loans made by non-Federal lenders to health centers, funded under this section, for the costs of developing and operating managed care networks or plans described in subsection (c)(1)(B), or practice management networks described in subsection (c)(1)(C), and for the costs of acquiring, leasing, modernizing, or expanding buildings, construction of buildings, or purchasing or leasing equipment.*

(B) USE OF FUNDS.—Loan funds guaranteed under this subsection may be used—

(i) to establish reserves for the furnishing of services on a pre-paid basis [or]

(ii) for costs incurred by the center or centers, otherwise permitted under this section, as the Secretary determines are necessary to enable a center or centers to develop, operate, and own the network or plan[.]*;*

(iii) to refinance an existing loan (as of the date of refinancing) to the center or centers, if the Secretary determines such refinancing will be beneficial to the health center and the Federal Government and will result in more favorable terms.

(D) LOAN GUARANTEES.—Notwithstanding any other provision of law, the following funds shall be made available until expended for loan guarantees under this subsection:

(i) Funds appropriated for fiscal year 1997 under the Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 1997, which were made available for loan guarantees for loans made by non-Federal lenders for construction, renovation, and modernization of medical facilities that are owned and operated by health centers and for loan guarantees for loans to health centers for the costs of developing and operating managed care networks or plans, and which have not been expended.

(ii) Funds appropriated for fiscal year 1998 under the Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 1998, which were made available for loan guarantees for loans made by non-Federal lenders for construction, renovation, and modernization of medical facilities that are owned or operated by health centers and for loan guarantees for loans to health centers under this subsection (as in effect on the day before the date of enactment of the Health Care Safety Net Amendments of 2001), and which have not been expended.

(E) PROVISION DIRECTLY TO NETWORKS OR PLANS.—At the request of health centers receiving assistance under this section, loan guarantees provided under this paragraph may be made directly to networks or plans that are at least majority controlled and, as applicable, at least majority owned by those health centers.

(F) FEDERAL CREDIT REFORM.—The requirements of the Federal Credit Reform Act of 1990 (2 U.S.C. 661 et seq.) shall apply with respect to loans refinanced under subparagraph (B)(iii),

* * * * * * *

[(6) ANNUAL REPORT.—Not later than April 1, 1998, and each April 1 thereafter, the Secretary shall prepare and submit to the appropriate committees of Congress a report concerning loan guarantees provided under this subsection. Such report shall include—

[(A) a description of the number, amount, and use of funds received under each loan guarantee provided under this subsection;

[(B) a description of any defaults with respect to such loans and an analysis of the reasons for such defaults, if any; and

[(C) a description of the steps that may have been taken by the Secretary to assist an entity in avoiding such a default.

[(7) PROGRAM EVALUATION.—Not later than June 30, 1999, the Secretary shall prepare and submit to the appropriate committees of Congress a report containing an evaluation of the program authorized under this subsection. Such evaluation shall include a recommendation with respect to whether or not the loan guarantee program under this subsection should be continued and, if so, any modifications that should be made to such program.]

[(8)] *(6)* AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this subsection such sums as may be necessary.

(e) OPERATING GRANTS.—

(1) AUTHORITY.—

(A) IN GENERAL.— * * *

* * * * * * *

(B) ENTITIES THAT FAIL TO MEET CERTAIN REQUIREMENTS.—The Secretary may make grants, for a period of not to exceed 2 years, for the costs of the operation of public and nonprofit entities which provide health services to medically underserved populations but with respect to which the Secretary is unable to make each of the determinations required by [subsection (j)(3)] *subsection (l)(3).*

(C) OPERATION OF NETWORKS AND PLANS.—The Secretary may make grants to health centers that receive assistance under this section, or at the request of the health centers, directly to a network or plan (as described in subparagraphs (B) and (C) of subsection (c)(1)) that is at least majority controlled and, as applicable, at least majority owned by such health centers receiving assistance under this section, for the costs associated with the operation of such network or plan, including the purchase or lease of equipment (including the costs of amortizing the principal of, and paying the interest on, loans for equipment).

(2) USE OF FUNDS.—The costs for which a grant may be made under subparagraph (A) or (B) of paragraph (1) may include the costs of [acquiring and leasing] *acquiring, leasing, modernizing, and expanding* buildings [and equipment]*, constructing buildings, and purchasing or leasing equipment* (including the costs of amortizing the principal of, and paying interest on, [loans)] *loans for buildings and equipment)*, and the costs of providing training related to the provision of required primary health services and additional health services and to the management of health center programs. *The costs for which a grant may be made under paragraph (1)(C) may include the costs of providing such training.*

[(3) CONSTRUCTION.—The Secretary may award grants which may be used to pay the costs associated with expanding and modernizing existing buildings or constructing new buildings (including the costs of amortizing the principal of, and

paying the interest on, loans) for projects approved prior to October 1, 1996.]

* * * * * * *

[(4)] *(3)* LIMITATION.—Not more than two grants may be made under subparagraph (B) of paragraph (1) for the same entity.

[(5)] *(4)* AMOUNT.—

(A) IN GENERAL.—The amount of any grant made in any fiscal year under *subparagraphs (A) and (B) of* paragraph (1) to a health center shall be determined by the Secretary, but may not exceed the amount by which the costs of operation of the center in such fiscal year exceed the total of—

(i) State, local, and other operational funding provided to the center; and

(ii) the fees, premiums, and third-party reimbursements, which the center may reasonably be expected to receive for its operations in such fiscal year.

(B) NETWORKS AND PLANS.—The total amount of grant funds made available for any fiscal year under paragraph (1)(C) and subparagraphs (B) and (C) of subsection (c)(1) to a health center or to a network or plan shall be determined by the Secretary, but may not exceed 2 percent of the total amount appropriated under this section for such fiscal year.

[(B)] *(C)* PAYMENTS.—Payments under grants under subparagraph (A) or (B) of paragraph (1) shall be made in advance or by way of reimbursement and in such installments as the Secretary finds necessary and adjustments may be made for overpayments or underpayments.

[(C)] *(D)* USE OF NONGRANT FUNDS.—Nongrant funds described in clauses (i) and (ii) of subparagraph (A), including any such funds in excess of those originally expected, shall be used as permitted under this section, and may be used for such other purposes as are not specifically prohibited under this section if such use furthers the objectives of the project.

* * * * * * *

(g) MIGRATORY AND SEASONAL AGRICULTURAL WORKERS.—

(1) IN GENERAL.—

* * * * * * *

(2) ENVIRONMENTAL CONCERNS.—The Secretary may enter into grants or contracts under this subsection with public and private entities to—

(A) assist the States in the implementation and enforcement of acceptable environmental health standards, including enforcement of standards for sanitation in migratory agricultural worker *and seasonal agricultural worker* labor camps, and applicable Federal and State pesticide control standards; and

(B) conduct projects and studies to assist the several States and entities which have received grants or contracts under this section in the assessment of problems related to

camp and field sanitation, exposure to unsafe levels of agricultural chemicals including pesticides, and other environmental health hazards to which migratory agricultural workers [and members of their families] *and seasonal agricultural workers, and members of their families,* are exposed.

(3) DEFINITIONS.—For purposes of this subsection:

(A) MIGRATORY AGRICULTURAL WORKER.—The term "migratory agricultural worker" means an individual whose principal employment is in agriculture *on a seasonal basis*, who has been so employed within the last 24 months, and who establishes for the purposes of such employment a temporary abode.

* * * * * * *

(h) HOMELESS POPULATION.—

(1) IN GENERAL.—The Secretary may award grants for the purposes described in subsections (c), (e), and (f) for the planning and delivery of services to a special medically underserved population comprised of homeless individuals, including grants for innovative programs that provide outreach and comprehensive primary health services to [homeless children and children at risk of homelessness] *homeless children and youth and children and youth at risk of homelessness*.

* * * * * * *

(4) TEMPORARY CONTINUED PROVISION OF SERVICES TO CERTAIN FORMER HOMELESS INDIVIDUALS.—If any grantee under this subsection has provided services described in this section under the grant to a homeless individual, such grantee may, notwithstanding that the individual is no longer homeless as a result of becoming a resident in permanent housing, expend the grant to continue to provide such services to the individual for not more than 12 months.

[(4)] *(5)* DEFINITIONS.—For purposes of this section:

(A) HOMELESS INDIVIDUAL.—The term "homeless individual" means an individual who lacks housing (without regard to whether the individual is a member of a family), including an individual whose primary residence during the night is a supervised public or private facility that provides temporary living accommodations and an individual who is a resident in transitional housing.

(B) SUBSTANCE ABUSE.—The term "substance abuse" has the same meaning given such term in section 534(4).

(C) SUBSTANCE ABUSE SERVICES.—The term "substance abuse services" includes detoxification [and residential treatment], *risk reduction, outpatient treatment, residential treatment, and rehabilitation* for substance abuse provided in settings other than hospitals.

* * * * * * *

(j) ENVIRONMENTAL CONCERNS.—The Secretary may make grants to health centers for the purpose of assisting such centers in identifying and detecting environmental factors and conditions, and providing services, including environmental health services described

in subsection (b)(2)(D), to reduce the disease burden related to environmental factors and exposure of populations to such factors, and alleviate environmental conditions that affect the health of individuals and communities served by health centers funded under this section.

(k) LINGUISTIC ACCESS GRANTS.—

(1) IN GENERAL.—The Secretary may award grants to eligible health centers with a substantial number of clients with limited English speaking proficiency to provide translation, interpretation, and other such services for such clients with limited English speaking proficiency.

(2) ELIGIBLE HEALTH CENTER.—In this subsection, the term "eligible health center" means an entity that—

(A) is a health center as defined under subsection (a); and

(B) provides health care services for clients for whom English is a second language.

(3) GRANT AMOUNT.—The amount of a grant awarded to a center under this subsection shall be determined by the Administrator. Such determination of such amount shall be based on the number of clients for whom English is a second language that is served by such center, and larger grant amounts shall be awarded to centers serving larger number of such clients.

(4) USE OF FUNDS.—An eligible health center that receives a grant under this subsection may use funds received through such grant to—

(A) provide translation, interpretation, and other such services for clients for whom English is a second language, including hiring professional translation and interpretation services; and

(B) compensate bilingual or multilingual staff for language assistance services provided by the staff for such clients.

(5) APPLICATION.—An eligible health center desiring a grant under this subsection shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may reasonably require, including—

(A) an estimate of the number of clients that the center serves for whom English is a second language;

(B) the ratio of the number of clients for whom English is a second language to the total number of clients served by the center; and

(C) a description of any language assistance services that the center proposes to provide to aid clients for whom English is second language.

(6) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this subsection, in addition to any funds authorized to be appropriated or appropriated for health centers under any other subsection of this section, $10,000,000 for fiscal year 2002, and such sums as may be necessary for each of fiscal years 2003 through 2006.

[(j)] *(l)* APPLICATIONS.—

(1) SUBMISSION.—

* * * * * * *

(E) the center—

[(i)] *(i)(I)* has or will have a contractual or other arrangement with the agency of the State, in which it provides services, which administers or supervises the administration of a State plan approved under title XIX of the Social Security Act for the payment of all or a part of the center's costs in providing health services to persons who are eligible for medical assistance under such a State [plan; or] *plan; and*

(II) has or will have a contractual or other arrangement with the State agency administering the program under title XXI of such Act (42 U.S.C. 1397aa et seq.) with respect to individuals who are State children's health insurance program beneficiaries; or

[(ii) has made or will make every reasonable effort to enter into such an arrangement;]

(ii) has made or will make every reasonable effort to enter into arrangements described in subclauses (I) and (II) of clause (i);

* * * * * * *

(G) the center—

* * * * * * *

(II) to collect reimbursement for health services to persons described in subparagraph (F) on the basis of the full amount of fees and payments for such services without application of any discount; [and]

(iii)(I) will assure that no patient will be denied health care services due to an individual's inability to pay for such services; and

(II) will assure that any fees or payments required by the center for such services will be reduced or waived to enable the center to fulfill the assurance described in subclause (I); and

[(iii)] *(iv)* has submitted to the Secretary such reports as the Secretary may require to determine compliance with this subparagraph;

(H) * * *

* * * * * * *

(ii) meets at least once a month, selects the services to be provided by the center, schedules the hours during which such services will be provided, *reviews any internal outreach plans for specific subpopulations served by the center,* approves the center's annual budget, approves the selection of a director for the center, and, except in the case of a governing board of a public center (as defined in the second sentence of this paragraph), established general policies for the center; and

* * * * * * *

except that, upon a showing of good cause the Secretary shall waive, for the length of the project period, all or part of the requirements of this subparagraph in the case of a

health center that receives a grant pursuant to subsection (g), (h), (i), [or (p);] *or (q);*

* * * * * * *

(K) in the case of a center which serves a population including a substantial proportion of individuals of limited English-speaking ability, the center has—

* * * * * * *

(ii) identified an individual on its staff who is fluent in both that language and in English and whose responsibilities shall include providing guidance to such individuals and to appropriate staff members with respect to cultural sensitivities and bridging linguistic and cultural differences; [and]

* * * * * * *

(L) the center, has developed an ongoing referral relationship with one or more hospitals[.]*; and*

(M) in the case of a project involving modernization of a building, the application contains a reasonable assurance that all laborers and mechanics employed by contractors or subcontractors in the performance of work on the modernization of the building described in the application will be paid wages at rates not less than the rates prevailing on similar work in the locality involved as determined by the Secretary of Labor in accordance with the labor standards specified in the Act of March 3, 1931 (commonly known as the 'Davis-Bacon Act') (46 Stat. 1494, chapter 411; 40 U.S.C. 276a et seq.), and the Secretary of Labor shall have with respect to such labor standards and such project the authority and functions set forth in Reorganization Plan No. 14 of 1950 (50 U.S.C. App.) and section 2 of the Act of June 13, 1934 (48 Stat. 948, chapter 482; 40 U.S.C. 276c).

[(k) TECHNICAL AND OTHER ASSISTANCE.—The Secretary may provide (either through the Department of Health and Human Services or by grant or contract) all necessary technical and other nonfinancial assistance (including fiscal and program management assistance and training in such management) to any public or private nonprofit entity to assist entities in developing plans for, or operating as, health centers, and in meeting the requirements of subsection (j)(2)]

(m) TECHNICAL ASSISTANCE.—The Secretary shall establish a program through which the Secretary shall provide technical and other assistance to eligible entities to assist such entities to meet the requirements of subsection (l)(3) in developing plans for, or operating, health centers. Services provided through the program may include necessary technical and nonfinancial assistance, including fiscal and program management assistance, training in fiscal and program management, operational and administrative support, and the provision of information to the entities of the variety of resources available under this title and how those resources can be best used to meet the health needs of the communities served by the entities.

[(m)] *(n)* MEMORANDUM OF AGREEMENT.—In carrying out this section, the Secretary may enter into a memorandum of agreement with a State. Such memorandum may include, where appropriate, provisions permitting such State to—

[(n)] *(o)* RECORDS.—

[(o)] *(p)* DELEGATION OF AUTHORITY.—The Secretary may delegate the authority to administer the programs authorized by this section to any office, except that the authority to enter into, modify, or issue approvals with respect to grants or contracts may be delegated only within the central office of the Health Resources and Services Administration.

[(p)] *(q)* SPECIAL CONSIDERATION.—In making grants under this section, the Secretary shall give special consideration to the unique needs of sparsely populated rural areas, including giving priority in the awarding of grants for new health centers under subsections (c) and (e), and the granting of waivers as appropriate and permitted under subsections (b)(1)(B)(i) and [(j)(3)(G)] *(l)(3)(G)*.

[(q)] *(r)* AUDITS.—

(1) IN GENERAL.—Each entity which receives a grant under this section shall provide for an independent annual financial audit of any books, accounts, financial records, files, and other papers and property which relate to the disposition or use of the funds received under such grant and such other funds received by or allocated to the project for which such grant was made. For purposes of assuring accurate, current, and complete disclosure of the disposition or use of the funds received, each such audit shall be conducted in accordance with generally accepted accounting principles. Each audit shall evaluate—

[(l)] *(s)* AUTHORIZATION OF APPROPRIATIONS.—

(1) IN GENERAL.—For the purpose of carrying out this section, in addition to the amounts authorized to be appropriated under subsection (d), there are authorized to be appropriated [$802,124,000 for fiscal year 1997, and such sums as may be necessary for each of the fiscal years 1998 through 2001] *$1,369,000,000 for fiscal year 2002 and such sums as may be necessary for each of the fiscal years 2003 through 2006.*

(2) SPECIAL PROVISIONS.—

(A) PUBLIC CENTERS.—The Secretary may not expend in any fiscal year, for grants under this section to public centers (as defined in the second sentence of subsection [(j)(3))] *(l)(3))* the governing boards of which (as described in subsection [(j)(3)(G)(ii)] *(l)(3)(H))* do not establish general policies for such centers, an amount which exceeds 5 percent of the amounts appropriated under this section for that fiscal year. For purposes of applying the preceding sentence, the term "public centers" shall not include health centers that receive grants pursuant to subsection (h) or (i).

[(B) DISTRIBUTION OF GRANTS.—

[(i) FISCAL YEAR 1997.—For fiscal year 1997, the Secretary, in awarding grants under this section shall ensure that the amounts made available under each of subsections (g), (h), and (i) in such fiscal year bears the same relationship to the total amount appro-

priated for such fiscal year under paragraph (1) as the amounts appropriated for fiscal year 1996 under each of sections 329, 340, and 340A (as such sections existed one day prior to the date of enactment of this section) bears to the total amount appropriated under sections 329, 330, 340, and 340A (as such sections existed one day prior to the date of enactment of this section) for such fiscal year.

[(ii) FISCAL YEARS 1998 AND 1999.—For each of the fiscal years 1998 and 1999, the Secretary, in awarding grants under this section shall ensure that the proportion of the amount made available under each of subsections (g), (h), and (i) is equal to the proportion of amounts made available under each such subsection for the previous fiscal year, as such amounts relate to the total amounts appropriated for the previous fiscal year involved, increased or decreased by not more than 10 percent.]

(B) DISTRIBUTION OF GRANTS.—For fiscal year 2002 and each of the following fiscal years, the Secretary, in awarding grants under this section, shall ensure that the proportion of the amount made available under each of subsections (g), (h), and (i), relative to the total amount appropriated to carry out this section for that fiscal year, is equal to the proportion of the amount made available under that subsection for fiscal year 2001, relative to the total amount appropriated to carry out this section for fiscal year 2001.

[(3) FUNDING REPORT.—The Secretary shall annually prepare and submit to the appropriate committees of Congress a report concerning the distribution of funds under this section that are provided to meet the health care needs of medically underserved populations, including the homeless, residents of public housing, and migratory and seasonal agricultural workers, and the appropriateness of the delivery systems involved in responding to the needs of the particular populations. Such report shall include an assessment of the relative health care access needs of the targeted populations and the rationale for any substantial changes in the distribution of funds.]

(3) LIMITATION.—The total amount of grant funds made available in any fiscal year under subsections (c)(1)(A) and (e)(2), to support the costs of building construction or building expansion or modernization projects shall not exceed 5 percent of the total amount appropriated to carry out this section for such fiscal year.

* * * * * * *

[SEC. 330A. [254c] RURAL HEALTH OUTREACH, NETWORK DEVELOPMENT, AND TELEMEDICINE GRANT PROGRAM.

[(a) ADMINISTRATION.—The rural health services outreach demonstration grant program established under section 301 shall be administered by the Office of Rural Health Policy (of the Health Resources and Services Administration), in consultation with State rural health offices or other appropriate State governmental entities.

[(b) GRANTS.—Under the program referred to in subsection (a), the Secretary, acting through the Director of the Office of Rural Health Policy, may award grants to expand access to, coordinate, restrain the cost of, and improve the quality of essential health care services, including preventive and emergency services, through the development of integrated health care delivery systems or networks in rural areas and regions.

[(c) ELIGIBLE NETWORKS.—

[(1) OUTREACH NETWORKS.—To be eligible to receive a grant under this section, an entity shall—

[(A) be a rural public or nonprofit private entity that is or represents a network or potential network that includes three or more health care providers or other entities that provide or support the delivery of health care services; and

[(B) in consultation with the State office of rural health or other appropriate State entity, prepare and submit to the Secretary an application, at such time, in such manner, and containing such information as the Secretary may require, including—

[(i) a description of the activities which the applicant intends to carry out using amounts provided under the grant;

[(ii) a plan for continuing the project after Federal support is ended;

[(iii) a description of the manner in which the activities funded under the grant will meet health care needs of underserved rural populations within the State; and

[(iv) a description of how the local community or region to be served by the network or proposed net-work will be involved in the development and ongoing operations of the network.

[(2) FOR-PROFIT ENTITIES.—An eligible network may include for-profit entities so long as the network grantee is a nonprofit entity.

[(3) TELEMEDICINE NETWORKS.—

[(A) IN GENERAL.—An entity that is a health care provider and a member of an existing or proposed telemedicine network or an entity that is a consortium of health care providers that are members of an existing or proposed telemedicine network shall be eligible for a grant under this section.

[(B) REQUIREMENT.—A telemedicine network referred to in subparagraph (A) shall, at a minimum, be composed of—

[(i) a multispecialty entity that is located in an urban or rural area, which can provide 24-hour a day access to a range of specialty care; and

[(ii) at least two rural health care facilities, which may include rural hospitals, rural physician offices, rural health clinics, rural community health clinics, and rural nursing homes.

[(d) PREFERENCE.—In awarding grants under this section, the Secretary shall give preference to applicant networks that include—

[(1) a majority of the health care providers serving in the area or region to be served by the network;

[(2) any federally qualified health centers, rural health clinics, and local public health departments serving in the area or region;

[(3) outpatient mental health providers serving in the area or region; or

[(4) appropriate social service providers, such as agencies on aging, school systems, and providers under the women, infants, and children program, to improve access to and coordination of health care services.

[(e) USE OF FUNDS.—

[(1) IN GENERAL.—Amounts provided under grants awarded under this section shall be used—

[(A) for the planning and development of integrated self-sustaining health care networks; and

[(B) for the initial provision of services.

[(2) EXPENDITURES IN RURAL AREAS.—

[(A) IN GENERAL.—In awarding a grant under this section, the Secretary shall ensure that not less than 50 percent of the grant award is expended in a rural area or to provide services to residents of rural areas.

[(B) TELEMEDICINE NETWORKS.—An entity described in subsection (c)(3) may not use in excess of—

[(i) 40 percent of the amounts provided under a grant under this section to carry out activities under paragraph (3)(A)(iii); and

[(ii) 20 percent of the amounts provided under a grant under this section to pay for the indirect costs associated with carrying out the purposes of such grant.

[(3) TELEMEDICINE NETWORKS.—

[(A) IN GENERAL.—An entity described in subsection (c)(3), may use amounts provided under a grant under this section to—

[(i) demonstrate the use of telemedicine in facilitating the development of rural health care networks and for improving access to health care services for rural citizens;

[(ii) provide a baseline of information for a systematic evaluation of telemedicine systems serving rural areas;

[(iii) purchase or lease and install equipment; and

[(iv) operate the telemedicine system and evaluate the telemedicine system.

[(B) LIMITATIONS.—An entity described in subsection (c)(3), may not use amounts provided under a grant under this section—

[(i) to build or acquire real property;

[(ii) purchase or install transmission equipment (such as laying cable or telephone lines, microwave

towers, satellite dishes, amplifiers, and digital switching equipment); or

[(iii) for construction, except that such funds may be expended for minor renovations relating to the installation of equipment;

[(f) TERM OF GRANTS.—Funding may not be provided to a network under this section for in excess of a 3-year period.

[(g) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section there are authorized to be appropriated $36,000,000 for fiscal year 1997, and such sums as may be necessary for each of the fiscal years 1998 through 2001.]

"SEC. 330A. RURAL HEALTH CARE SERVICES OUTREACH, RURAL HEALTH NETWORK DEVELOPMENT, AND SMALL HEALTH CARE PROVIDER QUALITY IMPROVEMENT GRANT PROGRAMS.

(a) PURPOSE.—The purpose of this section is to provide grants for expanded delivery of health care services in rural areas, for the planning and implementation of integrated health care networks in rural areas, and for the planning and implementation of small health care provider quality improvement activities.

(b) DEFINITIONS.—

(1) DIRECTOR.—The term "Director" means the Director specified in subsection (d).

(2) FEDERALLY QUALIFIED HEALTH CENTER; RURAL HEALTH CLINIC.—The terms "Federally qualified health center" and "rural health clinic" have the meanings given the terms in section 1861(aa) of the Social Security Act (42 U.S.C. 1395x(aa)).

(3) HEALTH PROFESSIONAL SHORTAGE AREA.—The term "health professional shortage area" means a health professional shortage area designated under section 332.

(4) MEDICALLY UNDERSERVED COMMUNITY.—The term "medically underserved community" has the meaning given the term in section 799B.

(5) MEDICALLY UNDERSERVED POPULATION.—The term "medically underserved population" has the meaning given the term in section 330(b)(3).

(c) PROGRAM.—The Secretary shall establish, under section 301, a small health care provider quality improvement grant program.

(d) ADMINISTRATION.—

(1) PROGRAMS.—The rural health care services outreach, rural health network development, and small health care provider quality improvement grant programs established under section 301 shall be administered by the Director of the Office of Rural Health Policy of the Health Resources and Services Administration, in consultation with State offices of rural health or other appropriate State government entities.

(2) GRANTS.—

(A) IN GENERAL.—In carrying out the programs described in paragraph (1), the Director may award grants under subsections (e), (f), and (g) to expand access to, coordinate, and improve the quality of essential health care services, and enhance the delivery of health care, in rural areas.

(B) TYPES OF GRANTS.—The Director may award the grants—

(i) to promote expanded delivery of health care services in rural areas under subsection (e);

(ii) to provide for the planning and implementation of integrated health care networks in rural areas under subsection (f); and

(iii) to provide for the planning and implementation of small health care provider quality improvement activities under subsection (g).

(e) RURAL HEALTH CARE SERVICES OUTREACH GRANTS.—

(1) GRANTS.—The Director may award grants to eligible entities to promote rural health care services outreach by expanding the delivery of health care services to include new and enhanced services in rural areas. The Director may award the grants for periods of not more than 3 years.

(2) ELIGIBILITY.—To be eligible to receive a grant under this subsection for a project, an entity—

(A) shall be a rural public or rural nonprofit private entity;

(B) shall represent a consortium composed of members—

(i) that include 3 or more health care providers; and

(ii) that may be nonprofit or for-profit entities; and

(C) shall not previously have received a grant under this subsection for the same or a similar project, unless the entity is proposing to expand the scope of the project or the area that will be served through the project.

(3) APPLICATIONS.—To be eligible to receive a grant under this subsection, an eligible entity, in consultation with the appropriate State office of rural health or another appropriate State entity, shall prepare and submit to the Secretary an application, at such time, in such manner, and containing such information as the Secretary may require, including—

(A) a description of the project that the eligible entity will carry out using the funds provided under the grant;

(B) a description of the manner in which the project funded under the grant will meet the health care needs of rural underserved populations in the local community or region to be served;

(C) a description of how the local community or region to be served will be involved in the development and ongoing operations of the project;

(D) a plan for sustaining the project after Federal support for the project has ended;

(E) a description of how the project will be evaluated; and

(F) other such information as the Secretary determines to be appropriate.

(f) RURAL HEALTH NETWORK DEVELOPMENT GRANTS.—

(1) GRANTS.—

(A) IN GENERAL.—The Director may award rural health network development grants to eligible entities to promote, through planning and implementation, the development of integrated health care networks that have combined the functions of the entities participating in the networks in order to—

(i) achieve efficiencies;

(ii) expand access to, coordinate, and improve the quality of essential health care services; and

(iii) strengthen the rural health care system as a whole.

(B) GRANT PERIODS.—The Director may award such a rural health network development grant for implementation activities for a period of 3 years. The Director may also award such a rural health network development grant for planning activities for a period of 1 year, to assist in the development of an integrated health care network, if the proposed participants in the network do not have a history of collaborative efforts and a 3-year grant would be inappropriate.

(2) ELIGIBILITY.—To be eligible to receive a grant under this subsection, an entity—

(A) shall be a rural public or rural nonprofit private entity;

(B) shall represent a network composed of participants—

(i) that include 3 or more health care providers; and

(ii) that may be nonprofit or for-profit entities; and

(C) shall not previously have received a grant under this subsection (other than a grant for planning activities) for the same or a similar project.

(3) APPLICATIONS.—To be eligible to receive a grant under this subsection, an eligible entity, in consultation with the appropriate State office of rural health or another appropriate State entity, shall prepare and submit to the Secretary an application, at such time, in such manner, and containing such information as the Secretary may require, including—

(A) a description of the project that the eligible entity will carry out using the funds provided under the grant;

(B) an explanation of the reasons why Federal assistance is required to carry out the project;

(C) a description of—

(i) the history of collaborative activities carried out by the participants in the network;

(ii) the degree to which the participants are ready to integrate their functions; and

(iii) how the local community or region to be served will benefit from and be involved in the activities carried out by the network;

(D) a description of how the local community or region to be served will experience increased access to quality health care services across the continuum of care as a result of the integration activities carried out by the network;

(E) a plan for sustaining the project after Federal support for the project has ended;

(F) a description of how the project will be evaluated; and

(G) other such information as the Secretary determines to be appropriate.

(g) SMALL HEALTH CARE PROVIDER QUALITY IMPROVEMENT GRANTS.—

(1) GRANTS.—The Director may award grants to provide for the planning and implementation of small health care provider quality improvement activities. The Director may award the grants for periods of 1 to 3 years.

(2) ELIGIBILITY.—To be eligible for a grant under this subsection, an entity—

(A)(i) shall be a rural public or rural nonprofit private health care provider or provider of health care services, such as a critical access hospital or a rural health clinic; or

(ii) shall be another rural provider or network of small rural providers identified by the Secretary as a key source of local care; and

(B) shall not previously have received a grant under this subsection for the same or a similar project.

(3) APPLICATIONS.—To be eligible to receive a grant under this subsection, an eligible entity, in consultation with the appropriate State office of rural health or another appropriate State entity, such as a hospital association, shall prepare and submit to the Secretary an application, at such time, in such manner, and containing such information as the Secretary may require, including—

(A) a description of the project that the eligible entity will carry out using the funds provided under the grant;

(B) an explanation of the reasons why Federal assistance is required to carry out the project;

(C) a description of the manner in which the project funded under the grant will assure continuous quality improvement in the provision of services by the entity;

(D) a description of how the local community or region to be served will experience increased access to quality health care services across the continuum of care as a result of the activities carried out by the entity;

(E) a plan for sustaining the project after Federal support for the project has ended;

(F) a description of how the project will be evaluated; and

(G) other such information as the Secretary determines to be appropriate.

(4) EXPENDITURES FOR SMALL HEALTH CARE PROVIDER QUALITY IMPROVEMENT GRANTS.—In awarding a grant under this subsection, the Director shall ensure that the funds made available through the grant will be used to provide services to residents of rural areas. The Director shall award not less than 50 percent of the funds made available under this subsection to providers located in and serving rural areas.

(h) GENERAL REQUIREMENTS.—

(1) PROHIBITED USES OF FUNDS.—An entity that receives a grant under this section may not use funds provided through the grant—

(A) to build or acquire real property; or

(B) for construction, except that such funds may be expended for minor renovations relating to the installation of equipment.

(2) COORDINATION WITH OTHER AGENCIES.—The Secretary shall coordinate activities carried out under grant programs described in this section, to the extent practicable, with Federal and State agencies and nonprofit organizations that are operating similar grant programs, to maximize the effect of public dollars in funding meritorious proposals.

(3) PREFERENCE.—In awarding grants under this section, the Secretary shall give preference to entities that—

(A) are located in health professional shortage areas or medically underserved communities, or serve medically underserved populations; or

(B) propose to develop projects with a focus on primary care, and wellness and prevention strategies.

(i) REPORT.—Not later than September 30, 2005, the Secretary shall prepare and submit to the appropriate committees of Congress a report on the progress and accomplishments of the grant programs described in subsections (e), (f), and (g).

(j) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section $40,000,000 for fiscal year 2002, and such sums as may be necessary for each of fiscal years 2003 through 2006.

SEC. 330I. TELEHEALTH NETWORK AND TELEHEALTH RESOURCE CENTERS GRANT PROGRAMS.

(a) DEFINITIONS.—In this section:

(1) DIRECTOR; OFFICE.—The terms "Director" and "Office" mean the Director and Office specified in subsection (c).

(2) FEDERALLY QUALIFIED HEALTH CENTER AND RURAL HEALTH CLINIC.—The term "Federally qualified health center" and "rural health clinic" have the meanings given the terms in section 1861(aa) of the Social Security Act (42 U.S.C. 1395x(aa)).

(3) FRONTIER COMMUNITY.—The term "frontier community" shall have the meaning given the term in regulations issued under subsection (r).

(4) MEDICALLY UNDERSERVED AREA.—The term "medically underserved area" has the meaning given the term "medically underserved community" in section 799B.

(5) MEDICALLY UNDERSERVED POPULATION.—The term "medically underserved population" has the meaning given the term in section 330(b)(3).

(6) TELEHEALTH SERVICES.—The term "telehealth services" means services provided through telehealth technologies.

(7) TELEHEALTH TECHNOLOGIES.—The term "telehealth technologies" means technologies relating to the use of electronic information, and telecommunications technologies, to support and promote, at a distance, health care, patient and professional health-related education, health administration, and public health.

(b) PROGRAMS.—The Secretary shall establish, under section 301, telehealth network and telehealth resource centers grant programs.

(c) ADMINISTRATION.—

(1) ESTABLISHMENT.—There is established in the Health and Resources and Services Administration an Office for the Ad-

vancement of Telehealth. The Office shall be headed by a Director.

(2) DUTIES.—The telehealth network and telehealth resource centers grant programs established under section 301 shall be administered by the Director, in consultation with the State offices of rural health, State offices concerning primary care, or other appropriate State government entities.

(d) GRANTS.—

(1) TELEHEALTH NETWORK GRANTS.—The Director may, in carrying out the telehealth network grant program referred to in subsection (b), award grants to eligible entities for projects to demonstrate how telehealth technologies can be used through telehealth networks in rural areas, frontier communities, and medically underserved areas, and for medically underserved populations, to—

(A) expand access to, coordinate, and improve the quality of health care services;

(B) improve and expand the training of health care providers; and

(C) expand and improve the quality of health information available to health care providers, and patients and their families, for decisionmaking.

(2) TELEHEALTH RESOURCE CENTERS GRANTS.—The Director may, in carrying out the telehealth resource centers grant program referred to in subsection (b), award grants to eligible entities for projects to demonstrate how telehealth technologies can be used in the areas and communities, and for the populations, described in paragraph (1), to establish telehealth resource centers.

(e) GRANT PERIODS.—The Director may award grants under this section for periods of not more than 4 years.

(f) ELIGIBLE ENTITIES.—

(1) TELEHEALTH NETWORK GRANTS.—

(A) GRANT RECIPIENT.—To be eligible to receive a grant under subsection (d)(1), an entity shall be a nonprofit entity.

(B) TELEHEALTH NETWORKS.—

(i) IN GENERAL.—To be eligible to receive a grant under subsection (d)(1), an entity shall demonstrate that the entity will provide services through a telehealth network.

(ii) NATURE OF ENTITIES.—Each entity participating in the telehealth network may be a nonprofit or forprofit entity.

(iii) COMPOSITION OF NETWORK.—The telehealth network shall include at least 2 of the following entities (at least 1 of which shall be a community-based health care provider):

(I) Community or migrant health centers or other Federally qualified health centers.

(II) Health care providers, including pharmacists, in private practice.

(III) Entities operating clinics, including rural health clinics.

(IV) Local health departments.

(V) Nonprofit hospitals, including community access hospitals.

(VI) Other publicly funded health or social service agencies.

(VII) Long-term care providers.

(VIII) Providers of health care services in the home.

(IX) Providers of outpatient mental health services and entities operating outpatient mental health facilities.

(X) Local or regional emergency health care providers.

(XI) Institutions of higher education.

(XII) Entities operating dental clinics.

(2) TELEHEALTH RESOURCE CENTERS GRANTS.—To be eligible to receive a grant under subsection (d)(2), an entity shall be a nonprofit entity.

(g) APPLICATIONS.—To be eligible to receive a grant under subsection (d), an eligible entity, in consultation with the appropriate State office of rural health or another appropriate State entity, shall prepare and submit to the Secretary an application, at such time, in such manner, and containing such information as the Secretary may require, including—

(1) a description of the project that the eligible entity will carry out using the funds provided under the grant;

(2) a description of the manner in which the project funded under the grant will meet the health care needs of rural or other populations to be served through the project, or improve the access to services of, and the quality of the services received by, those populations;

(3) evidence of local support for the project, and a description of how the areas, communities, or populations to be served will be involved in the development and ongoing operations of the project;

(4) a plan for sustaining the project after Federal support for the project has ended;

(5) information on the source and amount of non-Federal funds that the entity will provide for the project;

(6) information demonstrating the long-term viability of the project, and other evidence of institutional commitment of the entity to the project;

(7) in the case of an application for a project involving a telehealth network, information demonstrating how the project will promote the integration of telehealth technologies into the operations of health care providers, to avoid redundancy, and improve access to and the quality of care; and

(8) other such information as the Secretary determines to be appropriate.

(h) TERMS; CONDITIONS; MAXIMUM AMOUNT OF ASSISTANCE.—The Secretary shall establish the terms and conditions of each grant program described in subsection (b) and the maximum amount of a grant to be awarded to an individual recipient for each fiscal year under this section. The Secretary shall publish, in a publication of

the Health Resources and Services Administration, notice of the application requirements for each grant program described in subsection (b) for each fiscal year.

(i) PREFERENCES.—

(1) TELEHEALTH NETWORKS.—In awarding grants under subsection (d)(1) for projects involving telehealth networks, the Secretary shall give preference to an eligible entity that meets at least 1 of the following requirements:

(A) ORGANIZATION.—The eligible entity is a rural community-based organization or another community-based organization.

(B) SERVICES.—The eligible entity proposes to use Federal funds made available through such a grant to develop plans for, or to establish, telehealth networks that provide mental health, public health, long-term care, home care, preventive, or case management services.

(C) COORDINATION.—The eligible entity demonstrates how the project to be carried out under the grant will be coordinated with other relevant federally funded projects in the areas, communities, and populations to be served through the grant.

(D) NETWORK.—The eligible entity demonstrates that the project involves a telehealth network that includes an entity that—

(i) provides clinical health care services, or educational services for health care providers and for patients or their families; and

(ii) is—

(I) a public school;

(II) a public library;

(III) an institution of higher education; or

(IV) a local government entity.

(E) CONNECTIVITY.—The eligible entity proposes a project that promotes local connectivity within areas, communities, or populations to be served through the project.

(F) INTEGRATION.—The eligible entity demonstrates that health care information has been integrated into the project.

(2) TELEHEALTH RESOURCE CENTERS.—In awarding grants under subsection (d)(2) for projects involving telehealth resource centers, the Secretary shall give preference to an eligible entity that meets at least 1 of the following requirements:

(A) PROVISION OF SERVICES.—The eligible entity has a record of success in the provision of telehealth services to medically underserved areas or medically underserved populations.

(B) COLLABORATION AND SHARING OF EXPERTISE.—The eligible entity has a demonstrated record of collaborating and sharing expertise with providers of telehealth services at the national, regional, State, and local levels.

(C) BROAD RANGE OF TELEHEALTH SERVICES.—The eligible entity has a record of providing a broad range of telehealth services, which may include—

(i) a variety of clinical specialty services;

(ii) patient or family education;
(iii) health care professional education; and
(iv) rural residency support programs.

(j) DISTRIBUTION OF FUNDS.—

(1) IN GENERAL.—In awarding grants under this section, the Director shall ensure, to the greatest extent possible, that such grants are equitably distributed among the geographical regions of the United States.

(2) TELEHEALTH NETWORKS.—In awarding grants under subsection (d)(1) for a fiscal year, the Director shall ensure that—

(A) not less than 50 percent of the funds awarded shall be awarded for projects in rural areas; and

(B) the total amount of funds awarded for such projects for that fiscal year shall be not less than the total amount of funds awarded for such projects for fiscal year 2001 under section 330A (as in effect on the day before the date of enactment of the Health Care Safety Net Amendments of 2001).

(k) USE OF FUNDS.—

(1) TELEHEALTH NETWORK PROGRAM.—The recipient of a grant under subsection (d)(1) may use funds received through such grant for salaries, equipment, and operating or other costs, including the cost of—

(A) developing and delivering clinical telehealth services that enhance access to community-based health care services in rural areas, frontier communities, or medically underserved areas, or for medically underserved populations;

(B) developing and acquiring, through lease or purchase, computer hardware and software, audio and video equipment, computer network equipment, interactive equipment, data terminal equipment, and other equipment that furthers the objectives of the telehealth network grant program;

(C)(i) developing and providing distance education, in a manner that enhances access to care in rural areas, frontier communities, or medically underserved areas, or for medically underserved populations; or

(ii) mentoring, precepting, or supervising health care providers and students seeking to become health care providers, in a manner that enhances access to care in the areas and communities, or for the populations, described in clause (i);

(D) developing and acquiring instructional programming;

(E)(i) providing for transmission of medical data, and maintenance of equipment; and

(ii) providing for compensation (including travel expenses) of specialists, and referring health care providers, who are providing telehealth services through the telehealth network, if no third party payment is available for the telehealth services delivered through the telehealth network;

(F) developing projects to use telehealth technology to facilitate collaboration between health care providers;

(G) collecting and analyzing usage statistics and data to document the cost-effectiveness of the telehealth services; and

(H) carrying out such other activities as are consistent with achieving the objectives of this section, as determined by the Secretary.

(2) TELEHEALTH RESOURCE CENTERS.—The recipient of a grant under subsection (d)(2) may use funds received through such grant for salaries, equipment, and operating or other costs for—

(A) providing technical assistance, training, and support, and providing for travel expenses, for health care providers and a range of health care entities that provide or will provide telehealth services;

(B) disseminating information and research findings related to telehealth services;

(C) promoting effective collaboration among telehealth resource centers and the Office;

(D) conducting evaluations to determine the best utilization of telehealth technologies to meet health care needs;

(E) promoting the integration of the technologies used in clinical information systems with other telehealth technologies;

(F) fostering the use of telehealth technologies to provide health care information and education for health care providers and consumers in a more effective manner; and

(G) implementing special projects or studies under the direction of the Office.

(l) PROHIBITED USES OF FUNDS.—An entity that receives a grant under this section may not use funds made available through the grant—

(1) to acquire real property;

(2) for expenditures to purchase or lease equipment, to the extent that the expenditures would exceed 40 percent of the total grant funds;

(3) in the case of a project involving a telehealth network, to purchase or install transmission equipment (such as laying cable or telephone lines, or purchasing or installing microwave towers, satellite dishes, amplifiers, or digital switching equipment), except on the premises of an entity participating in the telehealth network;

(4) to pay for any equipment or transmission costs not directly related to the purposes for which the grant is awarded;

(5) to purchase or install general purpose voice telephone systems;

(6) for construction, except that such funds may be expended for minor renovations relating to the installation of equipment; or

(7) for expenditures for indirect costs (as determined by the Secretary), to the extent that the expenditures would exceed 20 percent of the total grant funds.

(m) COLLABORATION.—In providing services under this section, an eligible entity shall collaborate, if feasible, with entities that—

(1)(A) are private or public organizations, that receive Federal or State assistance; or

(B) are public or private entities that operate centers, or carry out programs, that receive Federal or State assistance; and

(2) provide telehealth services or related activities.

(n) COORDINATION WITH OTHER AGENCIES.—The Secretary shall coordinate activities carried out under grant programs described in subsection (b), to the extent practicable, with Federal and State agencies and nonprofit organizations that are operating similar programs, to maximize the effect of public dollars in funding meritorious proposals.

(o) OUTREACH ACTIVITIES.—The Secretary shall establish and implement procedures to carry out outreach activities to advise potential end users of telehealth services in rural areas, frontier communities, medically underserved areas, and medically underserved populations in each State about the grant programs described in subsection (b).

(p) TELEHEALTH.—It is the sense of Congress that, for purposes of this section, States should develop reciprocity agreements so that a provider of services under this section who is a licensed or otherwise authorized health care provider under the law of 1 or more States, and who, through telehealth technology, consults with a licensed or otherwise authorized health care provider in another State, is exempt, with respect to such consultation, from any State law of the other State that prohibits such consultation on the basis that the first health care provider is not a licensed or authorized health care provider under the law of that State.

(q) REPORT.—Not later than September 30, 2005, the Secretary shall prepare and submit to the appropriate committees of Congress a report on the progress and accomplishments of the grant programs described in subsection (b).

(r) REGULATIONS.—The Secretary shall issue regulations specifying, for purposes of this section, a definition of the term "frontier area". The definition shall be based on factors that include population density, travel distance in miles to the nearest medical facility, travel time in minutes to the nearest medical facility, and such other factors as the Secretary determines to be appropriate. The Secretary shall develop the definition in consultation with the Director of the Bureau of the Census and the Administrator of the Economic Research Service of the Department of Agriculture.

(s) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section—

(1) for grants under subsection (d)(1), $40,000,000 for fiscal year 2002, and such sums as may be necessary for each of fiscal years 2003 through 2006; and

(2) for grants under subsection (d)(2), $20,000,000 for fiscal year 2002, and such sums as may be necessary for each of fiscal years 2003 through 2006.

SEC. 330J. TELEHOMECARE DEMONSTRATION PROJECT.

(a) DEFINITIONS.—In this section:

(1) DISTANT SITE.—The term "distant site" means a site at which a certified home care provider is located at the time at which a health care service (including a health care item) is provided through a telecommunications system.

(2) TELEHOMECARE.—The term "telehomecare" means the provision of health care services through technology relating to the use of electronic information, or through telemedicine or telecommunication technology, to support and promote, at a distant site, the monitoring and management of home health care services for a resident of a rural area.

(b) ESTABLISHMENT.—Not later than 9 months after the date of enactment of the Health Care Safety Net Amendments of 2001, the Secretary shall establish and carry out a telehomecare demonstration project.

(c) GRANTS.—In carrying out the demonstration project referred to in subsection (b), the Secretary shall make not more than 5 grants to eligible certified home care providers, individually or as part of a network of home health agencies, for the provision of telehomecare to improve patient care, prevent health care complications, improve patient outcomes, and achieve efficiencies in the delivery of care to patients who reside in rural areas.

(d) PERIODS.—The Secretary shall make the grants for periods of not more than 3 years.

(e) APPLICATIONS.—To be eligible to receive a grant under this section, a certified home care provider shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

(f) USE OF FUNDS.—A provider that receives a grant under this section shall use the funds made available through the grant to carry out objectives that include—

(1) improving access to care for home care patients served by home health care agencies, improving the quality of that care, increasing patient satisfaction with that care, and reducing the cost of that care through direct telecommunications links that connect the provider with information networks;

(2) developing effective care management practices and educational curricula to train home care registered nurses and increase their general level of competency through that training; and

(3) developing curricula to train health care professionals, particularly registered nurses, serving home care agencies in the use of telecommunications.

(g) COVERAGE.—Nothing in this section shall be construed to supersede or modify the provisions relating to exclusion of coverage under section 1862(a) of the Social Security Act (42 U.S.C 1395y(a)), or the provisions relating to the amount payable to a home health agency under section 1895 of that Act (42 U.S.C. 1395fff).

(h) REPORT.—

(1) INTERIM REPORT.—The Secretary shall submit to Congress an interim report describing the results of the demonstration project.

(2) FINAL REPORT.—Not later than 6 months after the end of the last grant period for a grant made under this section, the Secretary shall submit to Congress a final report—

(A) describing the results of the demonstration project; and

(B) including an evaluation of the impact of the use of telehomecare, including telemedicine and telecommunications, on—

(i) access to care for home care patients; and

(ii) the quality of, patient satisfaction with, and the cost of, that care.

(i) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2002 through 2006.

SEC. 330K. RURAL EMERGENCY MEDICAL SERVICE TRAINING AND EQUIPMENT ASSISTANCE PROGRAM.

(a) GRANTS.—The Secretary, acting through the Administrator of the Health Resources and Services Administration (referred to in this section as the "Secretary") shall award grants to eligible entities to enable such entities to provide for improved emergency medical services in rural areas.

(b) ELIGIBILITY.—To be eligible to receive a grant under this section, an entity shall—

(1) be—

(A) a State emergency medical services office;

(B) a State emergency medical services association;

(C) a State office of rural health;

(D) a local government entity;

(E) a State or local ambulance provider; or

(F) any other entity determined appropriate by the Secretary; and

(2) prepare and submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require, that includes—

(A) a description of the activities to be carried out under the grant; and

(B) an assurance that the eligible entity will comply with the matching requirement of subsection (e).

(c) USE OF FUNDS.—An entity shall use amounts received under a grant made under subsection (a), either directly or through grants to emergency medical service squads that are located in, or that serve residents of, a nonmetropolitan statistical area, an area designated as a rural area by any law or regulation of a State, or a rural census tract of a metropolitan statistical area (as determined under the most recent Goldsmith Modification, originally published in a notice of availability of funds in the Federal Register on February 27, 1992, 57 Fed. Reg. 6725), to—

(1) recruit emergency medical service personnel;

(2) recruit volunteer emergency medical service personnel;

(3) train emergency medical service personnel in emergency response, injury prevention, safety awareness, and other topics relevant to the delivery of emergency medical services;

(4) fund specific training to meet Federal or State certification requirements;

(5) develop new ways to educate emergency health care providers through the use of technology-enhanced educational methods (such as distance learning);

(6) acquire emergency medical services equipment, including cardiac defibrillators;

(7) acquire personal protective equipment for emergency medical services personnel as required by the Occupational Safety and Health Administration; and

(8) educate the public concerning cardiopulmonary resuscitation, first aid, injury prevention, safety awareness, illness prevention, and other related emergency preparedness topics.

(d) PREFERENCE.—In awarding grants under this section the Secretary shall give preference to—

(1) applications that reflect a collaborative effort by 2 or more of the entities described in subparagraphs (A) through (F) of subsection (b)(1); and

(2) applications submitted by entities that intend to use amounts provided under the grant to fund activities described in any of paragraphs (1) through (5) of subsection (c).

(e) MATCHING REQUIREMENT.—The Secretary may not award a grant under this section to an entity unless the entity agrees that the entity will make available (directly or through contributions from other public or private entities) non-Federal contributions toward the activities to be carried out under the grant in an amount equal to 25 percent of the amount received under the grant.

(f) EMERGENCY MEDICAL SERVICES.—In this section, the term "emergency medical services"—

(1) means resources used by a qualified public or private nonprofit entity, or by any other entity recognized as qualified by the State involved, to deliver medical care outside of a medical facility under emergency conditions that occur—

(A) as a result of the condition of the patient; or

(B) as a result of a natural disaster or similar situation; and

(2) includes services delivered by an emergency medical services provider (either compensated or volunteer) or other provider recognized by the State involved that is licensed or certified by the State as an emergency medical technician or its equivalent (as determined by the State), a registered nurse, a physician assistant, or a physician that provides services similar to services provided by such an emergency medical services provider.

(g) AUTHORIZATION OF APPROPRIATIONS.—

(1) IN GENERAL.—There are authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2002 through 2006.

(2) ADMINISTRATIVE COSTS.—The Secretary may use not more than 10 percent of the amount appropriated under paragraph (1) for a fiscal year for the administrative expenses of carrying out this section.

SEC. 330L. MENTAL HEALTH SERVICES DELIVERED VIA TELEHEALTH.

(a) DEFINITIONS.—In this section:

(1) ELIGIBLE ENTITY.—The term "eligible entity" means a public or nonprofit private telehealth provider network that offers services that include mental health services provided by qualified mental health providers.

(2) QUALIFIED MENTAL HEALTH EDUCATION PROFESSIONALS.—The term "qualified mental health education professionals" refers to teachers, community mental health professionals, nurses, and other entities as determined by the Secretary who have ad-

ditional training in the delivery of information on mental illness to children and adolescents or who have additional training in the delivery of information on mental illness to the elderly.

(3) QUALIFIED MENTAL HEALTH PROFESSIONALS.—The term "qualified mental health professionals" refers to providers of mental health services reimbursed under the medicare program carried out under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) who have additional training in the treatment of mental illness in children and adolescents or who have additional training in the treatment of mental illness in the elderly.

(4) SPECIAL POPULATIONS.—The term "special populations" refers to the following 2 distinct groups:

(A) Children and adolescents located in public elementary and public secondary schools in mental health underserved rural areas or in mental health underserved urban areas.

(B) Elderly individuals located in long-term care facilities in mental health underserved rural areas.

(5) TELEHEALTH.—The term "telehealth" means the use of electronic information and telecommunications technologies to support long distance clinical health care, patient and professional health-related education, public health, and health administration.

(b) PROGRAM AUTHORIZED.—

(1) IN GENERAL.—The Secretary, acting through the Director of the Office for the Advancement of Telehealth of the Health Resources and Services Administration, shall award grants to eligible entities to establish demonstration projects for the provision of mental health services to special populations as delivered remotely by qualified mental health professionals using telehealth and for the provision of education regarding mental illness as delivered remotely by qualified mental health professionals and qualified mental health education professionals using telehealth.

(2) POPULATIONS SERVED.—The Secretary shall award the grants under paragraph (1) in a manner that distributes the grants so as to serve equitably the populations described in subparagraphs (A) and (B) of subsection (a)(4).

(c) AMOUNT.—Each entity that receives a grant under subsection (b) shall receive not less than $1,200,000 under the grant, and shall use not more than 40 percent of the grant funds for equipment.

(d) USE OF FUNDS.—

(1) IN GENERAL.—An eligible entity that receives a grant under this section shall use the grant funds—

(A) for the populations described in subsection (a)(4)(A)—

(i) to provide mental health services, including diagnosis and treatment of mental illness, in public elementary and public secondary schools as delivered remotely by qualified mental health professionals using telehealth;

(ii) to provide education regarding mental illness (including suicide and violence) in public elementary and

public secondary schools as delivered remotely by qualified mental health professionals and qualified mental health education professionals using telehealth, including education regarding early recognition of the signs and symptoms of mental illness, and instruction on coping and dealing with stressful experiences of childhood and adolescence (such as violence, social isolation, and depression); and

(iii) to collaborate with local public health entities to provide the mental health services; and

(B) for the populations described in subsection (a)(4)(B)—

(i) to provide mental health services, including diagnosis and treatment of mental illness, in long-term care facilities as delivered remotely by qualified mental health professionals using telehealth;

(ii) to provide education regarding mental illness to primary staff (including physicians, nurses, and nursing aides) as delivered remotely by qualified mental health professionals and qualified mental health education professionals using telehealth, including education regarding early recognition of the signs and symptoms of mental illness, and instruction on coping and dealing with stressful experiences of old age (such as loss of physical and cognitive capabilities, death of loved ones and friends, social isolation, and depression); and

(iii) to collaborate with local public health entities to provide the mental health services.

(2) OTHER USES.—An eligible entity that receives a grant under this section may also use the grant funds to—

(A) acquire telehealth equipment to use in public elementary and public secondary schools and long-term care facilities for the objectives of this section;

(B) develop curricula to support activities described in subparagraphs (A)(ii) and (B)(ii) of paragraph (1);

(C) pay telecommunications costs; and

(D) pay qualified mental health professionals and qualified mental health education professionals on a reasonable cost basis as determined by the Secretary for services rendered.

(3) PROHIBITED USES.—An eligible entity that receives a grant under this section shall not use the grant funds to—

(A) purchase or install transmission equipment (other than such equipment used by qualified mental health professionals to deliver mental health services using telehealth under the project involved); or

(B) build upon or acquire real property (except for minor renovations related to the installation of reimbursable equipment).

(e) EQUITABLE DISTRIBUTION.—In awarding grants under this section, the Secretary shall ensure, to the greatest extent possible, that such grants are equitably distributed among geographical regions of the United States.

(f) APPLICATION.—An entity that desires a grant under this section shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary determines to be reasonable.

(g) REPORT.—Not later than 4 years after the date of enactment of the Health Care Safety Net Amendments of 2001, the Secretary shall prepare and submit to the appropriate committees of Congress a report that shall evaluate activities funded with grants under this section.

(h) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, $20,000,000 for fiscal year 2002 and such sums as may be necessary for fiscal years 2003 through 2006.

SEC. 330M. SCHOOL-BASED HEALTH CENTER NETWORKS.

(a) ELIGIBLE ENTITY.—In this section, the term "eligible entity" means a nonprofit organization, such as a State school-based health center association, academic institution, or primary care association, that has experience working with low-income communities, schools, families, and school-based health centers.

(b) PROGRAM AUTHORIZED.—The Secretary shall award grants to eligible entities to establish statewide technical assistance centers and carry out activities described in subsection (c) through the centers.

(c) USE OF FUNDS.—An eligible entity that receives a grant under this section may use funds received through such grant to—

(1) establish a statewide technical assistance center that shall coordinate local, State, and Federal health care services, including primary, dental, and behavioral and mental health services, that contribute to the delivery of school-based health care for medically underserved individuals;

(2) conduct operational and administrative support activities for statewide school-based health center networks to maximize operational effectiveness and efficiency;

(3) provide technical support training, including training on topics regarding—

(A) identifying parent and community interests and priorities;

(B) assessing community health needs and resources;

(C) implementing accountability and management information systems;

(D) integrating school-based health centers with care provided by any other school-linked provider, and with community-based primary and specialty health care systems;

(E) securing third party payments through effective billing and collection systems;

(F) developing shared services and joint purchasing arrangements across provider networks;

(G) linking services with health care services provided by other programs, especially services provided under the medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) and the State Children's Health Insurance Program under title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.);

(H) contracting with managed care organizations; and

(I) assuring and improving clinical quality and improvement; and

(4) provide to interested communities technical assistance for the planning and implementation of school-based health centers.

(d) APPLICATION.—An eligible entity desiring a grant under this section shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may reasonably require, including—

(1) a description of the region that will receive service and the potential partners in such region;

(2) a description of the policy and program environment and the needs of the community that will receive service;

(3) a 1- to 3-year work plan that describes the goals and objectives of the entity, and any activities that the entity proposes to carry out; and

(4) a description of the organizational capacity of the entity and its experience in serving the region's school-based health center community.

(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, $5,000,000 for fiscal year 2002, and such sums as may be necessary for subsequent fiscal years.

* * * * * * *

Subpart V—Healthy Communities Access Program

SEC. 340. GRANTS TO STRENGTHEN THE EFFECTIVENESS, EFFICIENCY, AND COORDINATION OF SERVICES FOR THE UNINSURED AND UNDERINSURED.

(a) IN GENERAL.—The Secretary may award grants to eligible entities to assist in the development of integrated health care delivery systems to serve communities of individuals who are uninsured and individuals who are underinsured—

(1) to improve the efficiency of, and coordination among, the providers providing services through such systems;

(2) to assist communities in developing programs targeted toward preventing and managing chronic diseases; and

(3) to expand and enhance the services provided through such systems.

(b) ELIGIBLE ENTITIES.—To be eligible to receive a grant under this section, an entity shall be a public or nonprofit entity that—

(1) represents a consortium—

(A) whose principal purpose is to provide a broad range of coordinated health care services for a community defined in the entity's grant application as described in paragraph (2); and

(B) that includes a provider (unless such provider does not exist within the community, declines or refuses to participate, or places unreasonable conditions on their participation) that—

(i) serves the community; and

(ii)(I) is a Federally qualified health center (as defined in section 1861(aa) of the Social Security Act (42 U.S.C. 1395x(aa)));

(II) is a hospital with a low-income utilization rate (as defined in section 1923(b)(3) of the Social Security Act (42 U.S.C. 1396r–4(b)(3)), that is greater than 25 percent;

(III) is a public health department; and

(IV) is an interested public or private sector health care provider or an organization that has traditionally served the medically uninsured and underserved;

(2) submits to the Secretary an application, in such form and manner as the Secretary shall prescribe, that—

(A) defines a community of uninsured and underinsured individuals that consists of all such individuals—

(i) in a specified geographical area, such as a rural area; or

(ii) in a specified population within such an area, such as American Indians, Native Alaskans, Native Hawaiians, Hispanics, homeless individuals, migrant and seasonal farmworkers, individuals with disabilities, and public housing residents;

(B) identifies the providers who will participate in the consortium's program under the grant, and specifies each provider's contribution to the care of uninsured and underinsured individuals in the community, including the volume of care the provider provides to beneficiaries under the medicare, medicaid, and State child health insurance programs carried out under titles XVIII, XIX, and XXI of the Social Security Act (42 U.S.C. 1395 et seq., 1396 et seq., and 1397aa et seq.) and to patients who pay privately for services;

(C) describes the activities that the applicant and the consortium propose to perform under the grant to further the objectives of this section;

(D) demonstrates the consortium's ability to build on the current system (as of the date of submission of the application) for serving a community of uninsured and underinsured individuals by involving providers who have traditionally provided a significant volume of care for that community;

(E) demonstrates the consortium's ability to develop coordinated systems of care that either directly provide or ensure the prompt provision of a broad range of high-quality, accessible services, including, as appropriate, primary, secondary, and tertiary services, as well as substance abuse treatment and mental health services in a manner that assures continuity of care in the community;

(F) demonstrates the consortium's ability to create comprehensive programs to address the prevention and management of chronic diseases of high importance within the community, where applicable;

(G) provides evidence of community involvement in the development, implementation, and direction of the program that the entity proposes to operate;

(H) demonstrates the consortium's ability to ensure that individuals participating in the program are enrolled in public insurance programs for which the individuals are eligible;

(I) presents a plan for leveraging other sources of revenue, which may include State and local sources and private grant funds, and integrating current and proposed new funding sources in a way to assure long-term sustainability of the program;

(J) describes a plan for evaluation of the activities carried out under the grant, including measurement of progress toward the goals and objectives of the program and the use of evaluation findings to improve program performance;

(K) demonstrates fiscal responsibility through the use of appropriate accounting procedures and appropriate management systems;

(L) demonstrates the consortium's commitment to serve the community without regard to the ability of an individual or family to pay by arranging for or providing free or reduced charge care for the poor; and

(M) includes such other information as the Secretary may prescribe;

(3) agrees along with each of the participating providers identified under paragraph (2)(B) that each will commit to use grant funds awarded under this section to supplement, not supplant, any other sources of funding (including the value of any in-kind contributions) available to cover the expenditures of the consortium and of the participating providers in carrying out the activities for which the grant would be awarded; and

(4) has established or will establish before the receipt of any grant under this section, a decision-making body that has full and complete authority to determine and oversee all the activities undertaken by the consortium with funds made available through such grant and that includes representation from each of the following providers listed in (b)(1)(B) if they participate in the consortium.

(c) PRIORITIES.—In awarding grants under this section, the Secretary—

(1) shall accord priority to applicants that demonstrate the extent of unmet need in the community involved for a more coordinated system of care; and

(2) may accord priority to applicants that best promote the objectives of this section, taking into consideration the extent to which the application involved—

(A) identifies a community whose geographical area has a high or increasing percentage of individuals who are uninsured;

(B) demonstrates that the applicant has included in its consortium providers, support systems, and programs that

have a tradition of serving uninsured individuals and underinsured individuals in the community;

(C) shows evidence that the program would expand utilization of preventive and primary care services for uninsured and underinsured individuals and families in the community, including behavioral and mental health services, oral health services, or substance abuse services;

(D) proposes a program that would improve coordination between health care providers and appropriate social service providers, including local and regional human services agencies, school systems, and agencies on aging;

(E) demonstrates collaboration with State and local governments;

(F) demonstrates that the applicant makes use of non-Federal contributions to the greatest extent possible; or

(G) demonstrates a likelihood that the proposed program will continue after support under this section ceases.

(d) USE OF FUNDS.—

(1) USE BY GRANTEES.—

(A) IN GENERAL.—Except as provided in paragraphs (2) and (3), a grantee may use amounts provided under this section only for—

(i) direct expenses associated with planning and developing the greater integration of a health care delivery system, and operating the resulting system, so that the system either directly provides or ensures the provision of a broad range of culturally competent services, as appropriate, including primary, secondary, and tertiary services, as well as substance abuse treatment and mental health services; and

(ii) direct patient care and service expansions to fill identified or documented gaps within an integrated delivery system.

(B) SPECIFIC USES.—The following are examples of purposes for which a grantee may use grant funds under this section, when such use meets the conditions stated in subparagraph (A):

(i) Increases in outreach activities.

(ii) Improvements to case management.

(iii) Improvements to coordination of transportation to health care facilities.

(iv) Development of provider networks and other innovative models to engage physicians in voluntary efforts to serve the medically underserved within a community.

(v) Recruitment, training, and compensation of necessary personnel.

(vi) Acquisition of technology, such as telehealth technologies to increase access to tertiary care.

(vii) Identifying and closing gaps in health care services being provided.

(viii) Improvements to provider communication, including implementation of shared information systems or shared clinical systems.

(ix) Development of common processes for determining eligibility for the programs provided through the system, including creating common identification cards and single sliding scale discounts.

(x) Creation of a triage system to coordinate referrals and to screen and route individuals to appropriate locations of primary, specialty, and inpatient care.

(xi) Development of specific prevention and disease management tools and processes, including—

(I) carrying out a protocol or plan for each individual patient concerning what needs to be done, at what intervals, and by whom, for the patient;

(II) redesigning practices to incorporate regular patient contact, collection of critical data on health and disease status, and use of strategies to meet the educational and psychosocial needs of patients who may need to make lifestyle and other changes to manage their diseases;

(III) the promotion of the availability of specialized expertise through the use of—

(aa) teams of providers with specialized knowledge;

(bb) collaborative care arrangements;

(cc) computer decision support services; or

(dd) telehealth technologies.

(IV) providing patient educational and support tools that are culturally competent and meet appropriate health literacy and literacy requirements; and

(V) the collection of data related to patient care and outcomes.

(xii) Translation services.

(xiii) Carrying out other activities that may be appropriate to a community and that would increase access by the uninsured to health care, such as access initiatives for which private entities provide non-Federal contributions to supplement the Federal funds provided through the grants for the initiatives.

(2) DIRECT PATIENT CARE LIMITATION.—Not more than 15 percent of the funds provided under a grant awarded under this section may be used for providing direct patient care and services.

(3) RESERVATION OF FUNDS FOR NATIONAL PROGRAM PURPOSES.—The Secretary may use not more than 3 percent of funds appropriated to carry out this section for providing technical assistance to grantees, obtaining assistance of experts and consultants, holding meetings, development of tools, dissemination of information, evaluation, and carrying out activities that will extend the benefits of a program funded under this section to communities other than the community served by the program funded.

(e) GRANTEE REQUIREMENTS.—

(1) IN GENERAL.—A grantee under this section shall—

(A) report to the Secretary annually regarding—

(i) progress in meeting the goals and measurable objectives set forth in the grant application submitted by the grantee under subsection (b); and

(ii) such additional information as the Secretary may require; and

(B) provide for an independent annual financial audit of all records that relate to the disposition of funds received through the grant.

(2) PROGRESS.—The Secretary may not renew an annual grant under this section for an entity for a fiscal year unless the Secretary is satisfied that the consortium represented by the entity has made reasonable and demonstrable progress in meeting the goals and measurable objectives set forth in the entity's grant application for the preceding fiscal year.

(f) TECHNICAL ASSISTANCE.—The Secretary may, either directly or by grant or contract, provide any entity that receives a grant under this section with technical and other nonfinancial assistance necessary to meet the requirements of this section.

(g) REPORT.—Not later than September 30, 2005, the Secretary shall prepare and submit to the appropriate committees of Congress a report on the progress and accomplishments of the grant programs described in this section.

(h) DEMONSTRATION AUTHORITY.—The Secretary may make demonstration awards under this section to historically black medical schools for the purposes of—

(1) developing patient-based research infrastructure at historically black medical schools, which have an affiliation, or affiliations, with any of the providers identified in section (b)(1)(B);

(2) establishment of joint and collaborative programs of medical research and data collection between historically black medical schools and such providers, whose goal is to improve the health status of medically underserved populations; or

(3) supporting the research-related costs of patient care, data collection, and academic training resulting from such affiliations.

(i) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section $125,000,000 for fiscal year 2002 and such sums as may be necessary for each of fiscal years 2003 through 2006.

* * * * * * *

Subpart X—Primary Dental Programs

SEC. 340F. DESIGNATED DENTAL HEALTH PROFESSIONAL SHORTAGE AREA.

In this subpart, the term "designated dental health professional shortage area" means an area, population group, or facility that is designated by the Secretary as a dental health professional shortage area under section 332 or designated by the applicable State as having a dental health professional shortage.

SEC. 340G. GRANTS FOR INNOVATIVE PROGRAMS.

(a) GRANT PROGRAM AUTHORIZED.—The Secretary, acting through the Administrator of the Health Resources and Services Administration, is authorized to award grants to States for the purpose of helping States develop and implement innovative programs to address the dental workforce needs of designated dental health professional shortage areas in a manner that is appropriate to the States' individual needs.

(b) STATE ACTIVITIES.—A State receiving a grant under subsection (a) may use funds received under the grant for—

(1) loan forgiveness and repayment programs for dentists who—

(A) agree to practice in designated dental health professional shortage areas;

(B) are dental school graduates who agree to serve as public health dentists for the Federal, State, or local government; and

(C) agree to—

(i) provide services to patients regardless of such patients' ability to pay; and

(ii) use a sliding payment scale for patients who are unable to pay the total cost of services;

(2) dental recruitment and retention efforts;

(3) grants and low-interest or no-interest loans to help dentists who participate in the medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) to establish or expand practices in designated dental health professional shortage areas by equipping dental offices or sharing in the overhead costs of such practices;

(4) the establishment or expansion of dental residency programs in coordination with accredited dental training institutions in States without dental schools;

(5) programs developed in consultation with State and local dental societies to expand or establish oral health services and facilities in designated dental health professional shortage areas, including services and facilities for children with special needs, such as—

(A) the expansion or establishment of a community-based dental facility, free-standing dental clinic, consolidated health center dental facility, school-linked dental facility, or United States dental school-based facility;

(B) the establishment of a mobile or portable dental clinic; and

(C) the establishment or expansion of private dental services to enhance capacity through additional equipment or additional hours of operation;

(6) placement and support of dental students, dental residents, and advanced dentistry trainees;

(7) continuing dental education, including distance-based education;

(8) practice support through teledentistry conducted in accordance with State laws;

(9) community-based prevention services such as water fluoridation and dental sealant programs;

(10) coordination with local educational agencies within the State to foster programs that promote children going into oral health or science professions;

(11) the establishment of faculty recruitment programs at accredited dental training institutions whose mission includes community outreach and service and that have a demonstrated record of serving underserved States;

(12) the development of a State dental officer position or the augmentation of a State dental office to coordinate oral health and access issues in the State; and

(13) any other activities determined to be appropriate by the Secretary.

(c) APPLICATION.—

(1) IN GENERAL.—Each State desiring a grant under this section shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may reasonably require.

(2) ASSURANCES.—The application shall include assurances that the State will meet the requirements of subsection (d) and that the State possesses sufficient infrastructure to manage the activities to be funded through the grant and to evaluate and report on the outcomes resulting from such activities.

(d) MATCHING REQUIREMENT.—The Secretary may not make a grant to a State under this section unless that State agrees that, with respect to the costs to be incurred by the State in carrying out the activities for which the grant was awarded, the State will provide non-Federal contributions in an amount equal to not less than 40 percent of Federal funds provided under the grant. The State may provide the contributions in cash or in kind, fairly evaluated, including plant, equipment, and services and may provide the contributions from State, local, or private sources.

(e) REPORT.—Not later than 5 years after the date of enactment of the Health Care Safety Net Amendments of 2001, the Secretary shall prepare and submit to the appropriate committees of Congress a report containing data relating to whether grants provided under this section have increased access to dental services in designated dental health professional shortage areas.

(f) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, $50,000,000 for the 5-fiscal year period beginning with fiscal year 2002.

* * * * * * *

SEC. 1320a–7b. CRIMINAL PENALTIES FOR ACTS INVOLVING FEDERAL HEALTH CARE PROGRAMS.

* * * * * * *

(b) ILLEGAL REMUNERATIONS.—

(1) * * *

* * * * * * *

(3) Paragraphs (1) and (2) shall not apply to—

(A) * * *

(D) a waiver of any coinsurance under part B of subchapter XVIII of this chapter by [a Federally qualified health care center] *a rural health clinic (as defined in sec-*

tion 1861(aa)) to which members of the National Health Service Corps are assigned under section 333 of the Public Health Service Act, or a Federally qualified health center (as defined in section 1861(aa)) with respect to an individual who qualifies for subsidized services under a provision of the Public Health Service Act;

* * * * * * *

DEFENSE OF CERTAIN MALPRACTICE AND NEGLIGENCE SUITS

SEC. 224. (a) * * *

* * * * * * *

(G) * * *

(i) * * *

(ii) This section does not affect any authority of the entity to purchase medical malpractice liability insurance coverage with Federal funds provided to the entity under section 329, 330, [340] *330(h)*, or 340A.

* * * * * * *

(k)(1)(A) * * *

* * * * * * *

(2) Subject to appropriations, for each fiscal year, the Secretary shall establish a fund of an amount equal to the amount estimated under paragraph (1) that is attributable to entities receiving funds under each of the grant programs described in paragraph (4) of subsection (g), but not to exceed a total of $10,000,000 for each such fiscal year. Appropriations for purposes of this paragraph shall be made separate from appropriations made for purposes of sections 329, 330, [340] *330(h)*, and 340A.

* * * * * * *

(n)(1) Not later than one year after the date of the enactment of the Federally Supported Health Centers Assistance Act of 1995, the Comptroller General of the United States shall submit to the Congress a report on the following:

(A) * * *

* * * * * * *

(C) The value of private sector risk-management services, and the value of risk-management services and procedures required as a condition of receiving a grant under section 329, 330, [340] *330(h)*, or 340A.

* * * * * * *

SCREENINGS, REFERRALS, AND EDUCATION REGARDING LEAD POISONING

SEC. 317A. (a) AUTHORITY FOR GRANTS.—

(1) IN GENERAL.— * * *

* * * * * * *

(2) AUTHORITY REGARDING CERTAIN ENTITIES.—With respect to a geographic area with a need for activities authorized in paragraph (1), in any case in which neither the State nor the

political subdivision in which such area is located has applied for a grant under paragraph (1), the Secretary may make a grant under such paragraph to any grantee under section 329, 330, [340] *330(h)*, or 340A for carrying out such activities in the area.

* * * * * * *

PREVENTIVE HEALTH SERVICES REGARDING TUBERCULOSIS

SEC. 317E. (a) IN GENERAL.— * * *

* * * * * * *

(c) COOPERATION WITH PROVIDERS OF PRIMARY HEALTH SERVICES.—The Secretary may make a grant under subsection (a) of (b) only if the applicant for the grant agrees that, in carrying out activities under the grant, the applicant will cooperate with public and nonprofit private providers of primary health services or substance abuse services, including entities receiving assistance under section 329, 330, [340] *330(h)*, or 340A or under title V or XIX.

* * * * * * *

INFERTILITY AND SEXUALLY TRANSMITTED DISEASES

SEC. 318A. (a) IN GENERAL.— * * *

* * * * * * *

(e) REQUIRED PROVIDERS REGARDING CERTAIN SERVICES.—The Secretary may make a grant under subsection (a) only if the applicant involved agrees that, in expending the grant to carry out activities authorized in subsection (c), the services described in paragraphs (1) through (7) of such subsection will be provided only through entities that are State or local health departments, grantees under section 329, 330, [340] *330(h)*, 340A, or 1001, or are other public or nonprofit private entities that provide health services to a significant number of low-income women.

* * * * * * *

DESIGNATION OF HEALTH PROFESSIONAL SHORTAGE AREAS

SEC. 332. (a)(1) * * *
(2) * * *

* * * * * * *

(C) such a facility used in connection with the delivery of health services under section 321 (relating to hospitals), 322 (relating to care and treatment of persons under quarantine and others), 323 (relating to care and treatment of Federal prisoners), 324 (relating to examination and treatment of certain Federal employees), 325 (relating to examination of aliens), 326 (relating to services to certain Federal employees), 320 (relating to services for persons with Hansen's disease), or [340] *330(h)* (relating to the provision of health services to homeless individuals); and

* * * * * * *

BREAST AND CERVICAL CANCER INFORMATION

SEC. 340D. (a) IN GENERAL.— * * *

* * * * * * *

(c) RELEVANT ENTITIES.—The entities specified in this subsection are the following:

* * * * * * *

(5) Entities receiving assistance under section [340] *330(h)* (relating to homeless individuals).

* * * * * * *

SEC. 799B. DEFINITIONS.

For purposes of this title:

(1)(A) * * *

* * * * * * *

(6) The term "medically underserved community" means an urban or rural area or population that—

* * * * * * *

(B) is eligible to be served by a migrant health center under section 329, a community health center under section 330, a grantee under section [340] *330(h)* (relating to homeless individuals), or a grantee under section 340A (relating to residents of public housing);

* * * * * * *

LIMITATION ON SOURCE OF FUNDING FOR HEALTH MAINTENANCE ORGANIZATIONS

SEC. 1313. No funds appropriated under any provision of this Act (except as provided in sections 329, 330, and [340] *330(h)* other than this title may be used—

* * * * * * *

SEC. 2652. MINIMUM QUALIFICATIONS OF GRANTEES.

(a) IN GENERAL.—The entities referred to in section 2651(a) are public entities and nonprofit private entities that are—

* * * * * * *

(2) grantees under section [340] *330(h)* (regarding health services for the homeless);

* * * * * * *

SEC. 534. DEFINITIONS.

For purposes of this part:

(1) ELIGIBLE HOMELESS INDIVIDUAL.— * * *

(2) HOMELESS INDIVIDUAL.—The term "homeless individual" has the meaning given such term in section [340(r)] *330(h)(5)*.

* * * * * * *

NATIONAL HEALTH SERVICE CORPS

SEC. 331. (a)(1) * * *

* * * * * * *

(3) * * *

(A) * * *

* * * * * * *

(E)(i) The term "behavioral and mental health professionals" means health service psychologists, licensed clinical social workers, licensed professional counselors, marriage and family therapists, psychiatric nurse specialists, and psychiatrists.

(ii) The term "graduate program of behavioral and mental health" means a program that trains behavioral and mental health professionals.

(b)(1) The Secretary may conduct at schools of medicine, osteopathic medicine, dentistry, and, as appropriate, nursing and other schools of the [health professions] *health professions, including schools at which graduate programs of behavioral and mental health are offered,* and at entities which train allied health personnel, recruiting programs for the Corps, the Scholarship Program, and the Loan Repayment Program. Such recruiting programs shall include efforts to recruit individuals who will serve in the Corps other than pursuant to obligated service under the Scholarship or Loan Repayment Program.

(2) In the case of physicians, dentists, *behavioral and mental health professionals,* certified nurse midwives, certified nurse practitioners, and physician assistants who have an interest and a commitment to providing primary health care, the Secretary may establish fellowship programs to enable such health professionals to gain exposure to and expertise in the delivery of primary health services in health professional shortage areas. To the maximum extent practicable, the Secretary shall ensure that any such programs are established in conjunction with accredited residency programs, and other training programs, regarding such health professions.

[(c) The Secretary may reimburse applicants for positions in the Corps (including individuals considering entering into a written agreement pursuant to section 338D) for actual and reasonable expenses incurred in traveling to and from their places of residence to a health professional shortage area (designated under section 332) in which they may be assigned for the purpose of evaluating such area with regard to being assigned in such area. The Secretary shall not reimburse an applicant for more than one such trip.]

(c)(1) The Secretary may reimburse an applicant for a position in the Corps (including an individual considering entering into a written agreement pursuant to section 338D) for the actual and reasonable expenses incurred in traveling to and from the applicant's place of residence to an eligible site to which the applicant may be assigned under section 333 for the purpose of evaluating such site with regard to being assigned at such site. The Secretary may establish a maximum total amount that may be paid to an individual as reimbursement for such expenses.

(2) The Secretary may also reimburse the applicant for the actual and reasonable expenses incurred for the travel of 1 family member to accompany the applicant to such site. The Secretary may establish a maximum total amount that may be paid to an individual as reimbursement for such expenses.

(3) In the case of an individual who has entered into a contract for obligated service under the Scholarship Program or under the Loan Repayment Program, the Secretary may reimburse such individual for all or part of the actual and reasonable expenses incurred in transporting the individual, the individual's family, and the family's possessions to the site of the individual's assignment under section 333. The Secretary may establish a maximum total amount that may be paid to an individual as reimbursement for such expenses.

(i)(1) In carrying out subpart III, the Secretary may, in accordance with this subsection, carry out demonstration projects in which individuals who have entered into a contract for obligated service under the Loan Repayment Program receive waivers under which the individuals are authorized to satisfy the requirement of obligated service through providing clinical service that is not full-time.

(2) A waiver described in paragraph (1) may be provided by the Secretary only if—

(A) the entity for which the service is to be performed—

(i) has been approved under section 333A for assignment of a Corps member; and

(ii) has requested in writing assignment of a health professional who would serve less than full time;

(B) the Secretary has determined that assignment of a health professional who would serve less than full time would be appropriate for the area where the entity is located;

(C) a Corps member who is required to perform obligated service has agreed in writing to be assigned for less than full-time service to an entity described in subparagraph (A);

(D) the entity and the Corps member agree in writing that the less than full-time service provided by the Corps member will not be less than 16 hours of clinical service per week;

(E) the Corps member agrees in writing that the period of obligated service pursuant to section 338B will be extended so that the aggregate amount of less than full-time service performed will equal the amount of service that would be performed through full-time service under section 338C; and

(F) the Corps member agrees in writing that if the Corps member begins providing less than full-time service but fails to begin or complete the period of obligated service, the method stated in 338E(c) for determining the damages for breach of the individual's written contract will be used after converting periods of obligated service or of service performed into their full-time equivalents.

(3) In evaluating a demonstration project described in paragraph (1), the Secretary shall examine the effect of multidisciplinary teams.

DESIGNATION OF HEALTH PROFESSIONAL SHORTAGE AREAS

SEC. 332. (a)(1) For purposes of this subpart the term "health professional shortage area" means (A) an area in an urban or rural area (which need not conform to the geographic boundaries of a political subdivision and which is a rational area for the delivery of health services) which the Secretary determines has a health manpower shortage, (B) a population group which the Secretary deter-

mines has such a shortage, or (C) a public or nonprofit private medical facility or other public facility which the Secretary determines has such a shortage. *All Federally qualified health centers and rural health clinics, as defined in section 1861(aa) of the Social Security Act (42 U.S.C. 1395x(aa)), that meet the requirements of section 334 shall be automatically designated, on the date of enactment of the Health Care Safety Net Amendments of 2001, as having such a shortage. Not later than 5 years after such date of enactment, and every 5 years thereafter, each such center or clinic shall demonstrate that the center or clinic meets the applicable requirements of the Federal regulations, issued after the date of enactment of this Act, that revise the definition of a health professional shortage area for purposes of this section.* The Secretary shall not remove an area from the areas determined to be health professional shortage areas under subparagraph (A) of the preceding sentence until the Secretary has afforded interested persons and groups in such area an opportunity to provide data and information in support of the designation as a health professional shortage area or a population group described in subparagraph (B) of such sentence or a facility described in subparagraph (C) of such sentence, and has made a determination on the basis of the data and information submitted by such persons and groups and other data and information available to the Secretary.

* * * * * * *

(3) Homeless individuals (as defined in section [340(r)) may be a population group] *330(h)(4)), seasonal agricultural workers (as defined in section 330(g)(3)) and migratory agricultural workers (as so defined)), and residents of public housing (as defined in section 3(b)(1) of the United States Housing Act of 1937 (42 U.S.C. 1437a(b)(1))) may be population groups* under paragraph (1).

* * * * * * *

(b) * * *

(2) Indicators of a need, notwithstanding the supply of health manpower, for health services for the individuals in an area or population group or served by a medical facility or other public facility under consideration for designation.[, with special consideration to indicators of—

[(A) infant mortality,

[(B) access to health services,

[(C) health status, and

[(D) ability to pay for health services.]

* * * * * * *

(c) * * *

(2) The extent to which individuals who are (A) residents of the area, members of the population group, or patients in the medical facility or other public facility under consideration for designation, and (B) entitled to have payment made for medical services under title [XVIII or XIX] *XVIII, XIX, or XXI* of the Social Security Act, cannot obtain such services because of suspension of physicians from the programs under such titles.

* * * * * * *

(i) DISSEMINATION.—The Administrator of the Health Resources and Services Administration shall disseminate information concerning the designation criteria described in subsection (b) to—

(1) the Governor of each State;

(2) the representative of any area, population group, or facility selected by any such Governor to receive such information;

(3) the representative of any area, population group, or facility that requests such information; and

(4) the representative of any area, population group, or facility determined by the Administrator to be likely to meet the criteria described in subsection (b).

ASSIGNMENT OF CORPS PERSONNEL

SEC. 333. (a)(1) The Secretary may assign members of the Corps to provide, under regulations promulgated by the Secretary, health services in or to a health professional shortage area during the assignment period [specified in the agreement described in section 334] only if—

(A) a public or [nonprofit] private entity, which is located or has a demonstrated interest in such area, makes application to the Secretary for such assignment;

(B) such application has been approved by the Secretary;

[(C) an agreement has been entered into between the entity which has applied and the Secretary, in accordance with section 334; and]

(C) the entity agrees to comply with the requirements of section 334; and

* * * * * * *

(3) In approving applications for assignment of members of the Corps the Secretary shall not discriminate against applications from entities which are not receiving Federal financial assistance under this Act. *In approving such applications, the Secretary shall give preference to applications in which a nonprofit entity or public entity shall provide a site to which Corps members may be assigned.*

* * * * * * *

(d)(1) The Secretary [may] *shall* provide technical assistance to a public or [nonprofit] private entity which is located in a health professional shortage area and which desires to make an application under this section for assignment of a Corps member to such area. Assistance provided under this paragraph may include assistance to an entity in (A) analyzing the potential use of health professions personnel in defined health services delivery areas by the residents of such areas, (B) determining the need for such personnel in such areas, (C) determining the extent to which such areas will have a financial base to support the practice of such personnel and the extent to which additional financial resources are needed to adequately support the practice, [and] (D) determining the types of inpatient and other health services that should be provided by such personnel in such areas[.], *and (E) developing longterm plans for addressing health professional shortages and improving access to health care. The Secretary shall encourage entities that receive technical assistance under this paragraph to communicate with other communities, State Offices of Rural Health, State*

Primary Care Associations and Offices, and other entities concerned with site development and community needs assessment.

* * * * * * *

(2) The Secretary may provide, to public and [nonprofit] private entities which are located in a health professional shortage area to which area a Corps member has been assigned, technical assistance to assist in the retention of such member in such area after the completion of such member's assignment to the area.

SEC. 333A. PRIORITIES IN ASSIGNMENT OF CORPS PERSONNEL.

(a) IN GENERAL.— * * *

* * * * * * *

(A) is made regarding the provision of primary health services to a health professional shortage area with the greatest such shortage[, as determined in accordance with subsection (b)]; and

* * * * * * *

[(b) EXCLUSIVE FACTORS FOR DETERMINING GREATEST SHORTAGES.—In making a determination under subsection (a)(1)(A) of the health professional shortage areas with the greatest such shortages, the Secretary may consider only the following factors:

[(1) The ratio of available health manpower to the number of individuals in the area or population group involved, or served by the medical facility or other public facility involved.

[(2) Indicators of need as follows:

[(A) The rate of low birthweight births.

[(B) The rate of infant mortality.

[(C) The rate of poverty.

[(D) Access to primary health services, taking into account the distance to such services.]

[(c)] *(b)* ESTABLISHMENT OF CRITERIA FOR DETERMINING PRIORITIES.—

(1) IN GENERAL.—The Secretary shall establish criteria specifying the manner in which the Secretary makes a determination under subsection (a)(1)(A) of the health professional shortage areas with the greatest such shortages. [Such criteria shall specify the manner in which the factors described in subsection (b) are implemented regarding such a determination.]

* * * * * * *

[(d)] *(c)* NOTIFICATIONS REGARDING PRIORITIES.—

"(1) PROPOSED LIST.—The Secretary shall prepare and publish a proposed list of health professional shortage areas and entities that would receive priority under subsection (a)(1) in the assignment of Corps members. The list shall contain the information described in paragraph (2), and the relative scores and relative priorities of the entities submitting applications under section 333, in a proposed format. All such entities shall have 30 days after the date of publication of the list to provide additional data and information in support of inclusion on the list or in support of a higher priority determination and the

Secretary shall reasonably consider such data and information in preparing the final list under paragraph (2).

[(1)] *(2)* PREPARATION OF LIST FOR APPLICABLE PERIOD.—For the purpose of carrying out [paragraph (2)] *paragraph (3)*, the Secretary shall [prepare a list of health professional shortage areas] *prepare and, as appropriate, update a list of health professional shortage areas and entities* that are receiving priority under subsection (a)(1) in the assignment of Corps members [for the period applicable under subsection (f)]. Such list—

* * * * * * *

[(2)] *(3)* NOTIFICATION OF AFFECTED PARTIES.—

[(A) Not later than 30 days after the preparation of each list under paragraph (1), the Secretary shall notify entities specified for purposes of subparagraph (A) of such paragraph of the fact that the entities have been provided an authorization to receive assignments of Corps members in the event that Corps members are available for the assignments.

[(B) In the case of individuals with respect to whom a period of obligated service under the Scholarship Program will begin during the period under subsection (f) for which a list under paragraph (1) is prepared, the Secretary shall, not later than 30 days after the preparation of each such list, provide to such individuals the names of each of the entities specified for purposes of paragraph (1)(B)(i) that is appropriate to the medical speciality of the individuals.]

(3) NOTIFICATION OF AFFECTED PARTIES.—

(A) ENTITIES.—Not later than 30 days after the Secretary has added to a list under paragraph (2) an entity specified as described in subparagraph (A) of such paragraph, the Secretary shall notify such entity that the entity has been provided an authorization to receive assignments of Corps members in the event that Corps members are available for the assignments.

(B) INDIVIDUALS.—In the case of an individual obligated to provide service under the Scholarship Program, not later than 3 months before the date described in section 338C(b)(5), the Secretary shall provide to such individual the names of each of the entities specified as described in paragraph (2)(B)(i) that is appropriate for the individual's medical specialty and discipline.

[(3) REVISIONS IN LIST.—If the Secretary makes a revision in a list under paragraph (1) during the period under subsection (f) to which the list is applicable, and the revision alters the status of an entity with respect to the list, the Secretary shall notify the entity of the effect on the entity of the revision. Such notification shall be provided not later than 30 days after the date on which the revision is made.]

(4) REVISIONS.—If the Secretary proposes to make a revision in the list under paragraph (2), and the revision would adversely alter the status of an entity with respect to the list, the Secretary shall notify the entity of the revision. Any entity adversely affected by such a revision shall be notified in writing by the Secretary of the reasons for the revision and shall have

30 days to file a written appeal of the determination involved which shall be reasonably considered by the Secretary before the revision to the list becomes final. The revision to the list shall be effective with respect to assignment of Corps members beginning on the date that the revision becomes final.

[(e) *LIMITATION ON NUMBER OF ENTITIES OFFERED AS ASSIGNMENT CHOICES IN SCHOLARSHIP PROGRAM.*—

[(1) DETERMINATION OF AVAILABLE CORPS MEMBERS.—The Secretary shall determine the number of participants in the Scholarship Program who are available for assignments under section 333 for the period applicable under subsection (f).

[(2) AVAILABILITY OF 500 OR FEWER MEMBERS.—If the number of participants for purposes of paragraph (1) is less than 500, the Secretary shall limit the number of entities specified under subsection (d)(1)(B)(i) to the lesser of—

[(A) 500 such entities; and

[(B) a number of such entities constituting 300 percent of the number of such participants available for assignment under section 333.

[(3) AVAILABILITY OF MORE THAN 500 MEMBERS.—If the number of participants for purposes of paragraph (1) is equal to or greater than 500, the Secretary shall determine the number of entities to be specified under subsection (d)(1)(B)(i), subject to ensuring that assignments of such participants are made to 500 entities that serve health professional shortage areas that have chronic difficulty in recruiting and retaining health professionals to provide primary health services.

[(4) ADJUSTMENT IN BASE NUMBER.—The number 500, as used for purposes of paragraphs (2) and (3), may by regulation be adjusted by the Secretary to a greater or a lesser number.]

[(e)] *(d)* LIMITATION ON NUMBER OF ENTITIES OFFERED AS ASSIGNMENT CHOICES IN SCHOLARSHIP PROGRAM.—

(1) DETERMINATION OF AVAILABLE CORPS MEMBERS.—By April 1 of each calendar year, the Secretary shall determine the number of participants in the Scholarship Program who will be available for assignments under section 333 during the program year beginning on July 1 of that calendar year.

(2) DETERMINATION OF NUMBER OF ENTITIES.—At all times during a program year, the number of entities specified under subsection (c)(2)(B)(i) shall be—

(A) not less than the number of participants determined with respect to that program year under paragraph (1); and

(B) not greater than twice the number of participants determined with respect to that program year under paragraph (1).

[(f) APPLICABLE PERIOD REGARDING PRIORITIES.—

[(1) IN GENERAL.—With respect to determinations under subsection (a)(1) of the applications that are to be given priority regarding the assignment of Corps members, the Secretary shall make such a determination not less than once each fiscal year. The first determination shall be made not later than July 1 of the year preceding the year in which the period of obligated service begins. If the Secretary revises the determination before July 1 of the following year, the revised determination

shall be applicable with respect to assignments of Corps members made during the period beginning on the date of the issuance of the revised determination and ending on July 1 of such year.

[(2) DATE CERTAIN FOR PREPARATION OF NOTIFICATION LIST.—A list under subsection (d)(1) shall be prepared for each of the periods described in paragraph (1). Each such list shall be prepared not later than the date on which a determination of priorities under such paragraph is required to be made for the period involved.

[SEC. 334. (a) The Secretary shall require, as a condition to the approval of an application under section 333 for the assignment of a member of the Corps, that the entity which submitted the application enter into an agreement for a specific assignment period (not to exceed 4 years) with the Secretary under which—

[(1) the entity shall be responsible for charging, in accordance with subsection (d), for health services provided by Corps members assigned to the entity;

[(2) the entity shall take such action as may be reasonable for the collection of payments for such health services, including, if a Federal agency, an agency of a State or local government, or other third party would be responsible for all or part of the cost of such health services if it had not been provided by Corps members under this subpart, the collection, on a fee-for-service or other basis, from such agency or third party, the portion of such cost for which it would be so responsible (and in determining the amount of such cost which such agency or third party would be responsible, the health services provided by Corps members shall be considered as being provided by private practitioners);

[(3) the entity, if not a small health center, shall pay to the United States, as prescribed by the Secretary in each calendar quarter (or other period as may be specified in the agreement) during which any Corps member is assigned to such entity, the sum of—

[(A) an amount calculated by the Secretary to reflect the average salary (including amounts paid in accordance with section 331(d)) and allowances of comparable Corps members for a calendar quarter (or other period);

[(B) that portion of an amount calculated by the Secretary to reflect the average amount paid under the Scholarship Program or the Loan Repayment Program to or on behalf of comparable Corps members that bears the same ratio to the calculated amount as the number of days of service provided by the member during that quarter (or other period) bears to the number of days in his period of obligated service under the Scholarship Program or the Loan Repayment Program; and

[(C) if such entity received a loan under section 335(c) or a grant under section 333(d)(2), an amount which bears the same ratio to the amount of such loan or grant as the number of days in such quarter (or other period) during which any Corps members were assigned to the entity

bears to the number of days in the assignment period after such entity received such loan or grant;

[(4) the entity, if a small health center, shall pay to the United States, in each calendar quarter (or other period as may be specified in the agreement) during which any Corps members is assigned to such entity, an amount determined by the Secretary in accordance with subsection (f); and

[(5) the entity shall prepare and submit to the Secretary an annual report, in such form and manner, as the Secretary may require.

[(b)(1) The Secretary may waive in whole or in part, on a prospective or retrospective basis, the application of the requirement of subsection (a)(3) for an entity which is not a small health center if he determines that the entity is financially unable to meet such requirement of if he determines that compliance with such requirement would unreasonably limit the ability of the entity to provide for the adequate support of the provision of health services by Corps members.

[(2) The Secretary may waive in whole or in part, on a prospective or retrospective basis, the application of the requirement of subsection (a)(3) for any entity which is not a small health center and which is located in a health professional shortage area in which a significant percentage of the individuals are elderly, living in poverty, or have other characteristics which indicate an inability to repay, in whole or in part, the amounts required in subsection (a)(3).

[(3) In the event that the Secretary grants a waiver under paragraph (1) or (2), and does not, pursuant to paragraph (5), require payment by the entity in the amount described in subsection (f)(1) the entity shall be required to use the total amount of funds collected by such entity in accordance with subsection (a)(2) for the improvement of the capability of such entity to deliver health services to the individuals in, or served by, the health professional shortage area.

[(4) In determining whether to grant a waiver under paragraph (1) or (2), the Secretary shall not discriminate against a public entity.

[(5)(A) If the Secretary determines that an entity which is not a small health center is eligible for a waiver under paragraph (1) or (2), the Secretary may waive the application of subsection (a)(3) for such entity and require such entity to make payment in an amount equal to the amount described in subsection (f)(1) that would be payable by such entity if such entity were a small health center.

[(B) The Secretary may waive in whole or in part, on a prospective or retrospective basis, the application of the requirement of subparagraph (A) for any entity if the Secretary determines that the entity is financially unable to meet such requirement or that compliance with such requirement would unreasonably limit the ability of the entity to provide for the adequate support of the provision of health services by Corps members. Funds which would be paid to the United States but for a waiver under this subparagraph shall be used by an entity to—

[(i) expand or improve its provision of health services;

[(ii) increase the number of individuals served;

[(iii) renovate or modernize facilities for its provision of health services;

[(iv) improve the administration of its health service programs; or

[(v) to establish a financial reserve to assure its ability to continue providing health services.

[(c) The excess (if any) of the amount of funds collected by an entity which is not a small health center in accordance with subsection (a)(2) over the amount paid to the United States in accordance with subsection (a)(3) or subsection (b)(5)(A) shall be used by the entity to expand and improve the provision of health services to the individuals in the health professional shortage area for which the entity submitted an application or to recruit and retain health manpower to provide health services for such individuals.

[(d) Any person who receives health services provided by a Corps member under this subpart shall be charged for such services on a fee-for-service or other basis, at a rate approved by the Secretary, pursuant to regulations. Such rate shall be computed in such a way as to permit the recovery of the value of such services, except that if such person is determined under regulations of the Secretary to be unable to pay such charge, the Secretary shall provide for the furnishing of such services at a reduced rate or without charge.

[(e) Funds received by the Secretary under an agreement entered into under this section shall be deposited in the Treasury as miscellaneous receipts and shall be disregarded in determining the amounts of appropriations to be requested and the amounts to be made available from appropriations made under section 338 to carry out sections 331 through 335 and section 337.

[(f)(1) An entity which is a small health center shall pay to the United States, as prescribed by the Secretary in each calendar quarter (or other period as may be specified in the agreement) during which any Corps member is assigned to such entity, an amount equal to the amount (prorated for a calendar quarter or other period) by which the revenues that the center may reasonably expect to receive during an annual period for the provision of health services exceeds the costs that the center may reasonably expect to incur in the provision of such services, except that the amount that an entity shall pay to the United States under this paragraph shall not exceed the amount such entity would pay to the United States under paragraph (3) of subsection (a) if such paragraph applied to such entity.

[(2)(A) To determined for purposes of paragraph (1) the revenues and costs which an entity that is a small health center may reasonably be expected to receive and incur in an annual period for the provision of health services, the entity shall submit to the Secretary before the beginning of such period a proposed budget which—

[(i) describes the primary and supplemental health services (as defined in section 330) which are needed by the area the entity serves in such period; and

[(ii) states the revenues and costs which the entity expects to receive and incur in providing such health services in such period.

[(B) From the submission under subparagraph (A) and other information available to the Secretary, the Secretary shall determine—

[(i) the primary and supplemental health services (as defined in section 330) needed in the area the entity serves;

[(ii) the fees, premiums, third party reimbursements, and other revenues the entity making the submission may reasonably expect to receive from the provision of such services; and

[(iii) the costs which the entity may reasonably expect to incur in providing such services.

The revenues and costs determined by the Secretary shall be the revenues and costs used in making the determination under paragraph (1).

[(C)(i) A determination under subparagraph (B) regarding the revenues and costs of an entity in an annual period shall be made by the Secretary utilizing criteria specific to the entity and shall be made without regard to whether the entity is making progress toward collecting sufficient revenues to provide an adequate level of primary health services without the assignment of Corps members.

[(ii) In making a determination referred to in clause (i)—

[(I) the Secretary may consider whether the proposed budget submitted under subparagraph (A) provides a reasonable estimate regarding the revenues and costs of the entity; and

[(II) may not consider the reasonableness of the amount of revenues collected, or the amount of costs incurred by the entity, except to the extent necessary to ensure that the entity is operating in good faith and is operating efficiently with respect to fiscal matters within the control of the entity.

[(iii) A determination of whether an entity is eligible for a waiver under paragraph (3) shall be made by the Secretary without regard to the revenues and costs determined by the Secretary under subparagraph (B).

[(iv) A determination of whether an entity is a small health center shall be made by the Secretary without regard to the revenues and costs determined by the Secretary under subparagraph (B).

[(3) The Secretary may waive in whole or in part, on a prospective or retrospective basis, the application of paragraph (1) for an entity which is a small health center if the Secretary determines that the entity needs all or part of the amounts otherwise payable under such paragraph to—

[(A) expand or improve its provision of health services;

[(B) increase the number of individuals served;

[(C) renovate or modernize facilities for its provision of health services;

[(D) improve the administration of its health service programs; or

[(E) establish a financial reserve to assure its ability to continue providing health services.

[(4) The excess (if any) of the amount of funds collected by an entity which is a small health center in accordance with subsection (a)(2) over the amount paid to the United States in accordance with paragraph (1) of this subsection shall be used by the center for the purposes set out in subparagraph (A) through (E) of paragraph (3) of this subsection or to recruit and retain health manpower to pro-

vide health services to the individuals in the health professional shortage area for which the entity submitted an application.

[(5) For purposes of this section, the term "small health center" means an entity other than—

[(A) a hospital (or part of a hospital);

[(B) a public entity; or

[(C) an entity that is receiving a grant under section 329 or section 330, except that such term includes an entity whose grant is less than the total of the amounts, calculated on an annual basis, specified in subparagraphs (A) and (B) of subsection (a)(3).]

SEC. 334. CHARGES FOR SERVICES BY ENTITIES USING CORPS MEMBERS.

(a) AVAILABILITY OF SERVICES REGARDLESS OF ABILITY TO PAY OR PAYMENT SOURCE.—An entity to which a Corps member is assigned shall not deny requested health care services, and shall not discriminate in the provision of services to an individual—

(1) because the individual is unable to pay for the services; or

(2) because payment for the services would be made under—

(A) the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.);

(B) the medicaid program under title XIX of such Act (42 U.S.C. 1396 et seq.); or

(C) the State children's health insurance program under title XXI of such Act (42 U.S.C. 1397aa et seq.).

(b) CHARGES FOR SERVICES.—The following rules shall apply to charges for health care services provided by an entity to which a Corps member is assigned:

(1) IN GENERAL.—

(A) SCHEDULE OF FEES OR PAYMENTS.—Except as provided in paragraph (2), the entity shall prepare a schedule of fees or payments for the entity's services, consistent with locally prevailing rates or charges and designed to cover the entity's reasonable cost of operation.

(B) SCHEDULE OF DISCOUNTS.—Except as provided in paragraph (2), the entity shall prepare a corresponding schedule of discounts (including, in appropriate cases, waivers) to be applied to such fees or payments. In preparing the schedule, the entity shall adjust the discounts on the basis of a patient's ability to pay.

(C) USE OF SCHEDULES.—The entity shall make every reasonable effort to secure from patients fees and payments for services in accordance with such schedules, and fees or payments shall be sufficiently discounted in accordance with the schedule described in subparagraph (B).

(2) SERVICES TO BENEFICIARIES OF FEDERAL AND FEDERALLY ASSISTED PROGRAMS.—In the case of health care services furnished to an individual who is a beneficiary of a program listed in subsection (a)(2), the entity—

(A) shall accept an assignment pursuant to section 1842(b)(3)(B)(ii) of the Social Security Act (42 U.S.C. 1395u(b)(3)(B)(ii)) with respect to an individual who is a beneficiary under the medicare program; and

(B) shall enter into an appropriate agreement with—

(i) the State agency administering the program under title XIX of such Act with respect to an individual who is a beneficiary under the medicaid program; and

(ii) the State agency administering the program under title XXI of such Act with respect to an individual who is a beneficiary under the State children's health insurance program.

(3) COLLECTION OF PAYMENTS.—The entity shall take reasonable and appropriate steps to collect all payments due for health care services provided by the entity, including payments from any third party (including a Federal, State, or local government agency and any other third party) that is responsible for part or all of the charge for such services.

PROVISION OF HEALTH SERVICES BY CORPS MEMBERS

SEC. 335. (a) * * *

* * * * * * *

(e)(1)(A) * * *

(B) Any hospital which is found by the Secretary, after notice and an opportunity for a hearing on the record, to have violated this subsection shall upon such finding cease, for a period to be determined by the Secretary, to receive and to be eligible to receive any Federal funds under this Act or under titles [XVIII or XIX] *XVIII, XIX, or XXI* of the Social Security Act.

* * * * * * *

SEC. 336. FACILITATION OF EFFECTIVE PROVISION OF CORPS SERVICES.

(a) CONSIDERATION OF INDIVIDUAL CHARACTERISTICS OF MEMBERS IN MAKING ASSIGNMENTS.— * * *

* * * * * * *

(c) GRANTS REGARDING PREPARATION OF STUDENTS FOR PRACTICE.— With respect to individuals who have entered into contracts for obligated service under the Scholarship or Loan Repayment Program, the Secretary may make grants to, and enter into contracts with, public and nonprofit private entities (including health professions schools) for the conduct of programs designed to prepare such individuals for the effective provision of primary health services in the [health manpower] *health professional* shortage areas to which the individuals are assigned.

* * * * * * *

(f) DETERMINATIONS REGARDING EFFECTIVE SERVICE.—In carrying out subsection (a) and sections 338A(d) and 338B(d), the Secretary shall carry out activities to determine—

(1) the characteristics of physicians, dentists, and other health professionals who are more likely to remain in practice in [health manpower] *health professional* shortage areas after the completion of the period of service in the Corps;

* * * * * * *

ANNUAL REPORTS

SEC. 336A. The Secretary shall submit an annual report to Congress, and shall include in such report with respect to the previous calendar year—

* * * * * * *

(8) the amount charged during such year for health services provided by Corps members, the amount which collected in such year by entities in accordance with [agreements under] section 334, and the amount which was paid to the Secretary in such year under such agreements.

* * * * * * *

AUTHORIZATION OF APPROPRIATION

SEC. 338. (a)[(1) For] *For* the purpose of carrying out this subpart, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years [1991 through 2000] *2002 through 2006*.

[(2) In the case of individuals who serve in the Corps other than pursuant to obligated service under the Scholarship or Loan Repayment Program, the Secretary each fiscal year shall, to the extent practicable, make assignments under section 333 of such individuals who are certified nurse midwives, certified nurse practitioners, or physician assistants.]

* * * * * * *

Subpart III—Scholarship Program and Loan Repayment Program

NATIONAL HEALTH SERVICE CORPS SCHOLARSHIP PROGRAM

SEC. 338A. (a) * * *

(1) an adequate supply of physicians, dentists, *behavioral and mental health professionals,* certified nurse midwives, certified nurse practitioners, and physician assistants; and

* * * * * * *

(b) To be eligible to participate in the Scholarship Program, an individual must—

(1) be accepted for enrollment, or be enrolled, as a full-time student (A) in an accredited (as determined by the Secretary) educational institution in a State and (B) in a course of study or program, offered by such institution and approved by the Secretary, leading to a degree in medicine, osteopathic medicine, dentistry, or other health profession*, or an appropriate degree from a graduate program of behavioral and mental health*;

* * * * * * *

(c)(1) In disseminating application forms and contract forms to individuals desiring to participate in the Scholarship Program, the Secretary shall include with such forms—

(A) a fair summary of the rights and liabilities of an individual whose application is approved (and whose contract is accepted) by the Secretary, including in the summary a clear ex-

planation of the damages to which the United States is entitled under section [338D] *338E* in the case of the individual's breach of the contract; and

(B) the Secretary, in considering applications from individuals accepted for enrollment or enrolled in dental school, shall consider applications from all individuals accepted for enrollment or enrolled in any accredited dental school in a State; and

[(B)] *(C)* information respecting meeting a service obligation through private practice under an agreement under section [338C] *338D* and such other information as may be necessary for the individual to understand the individual's prospective participation in the Scholarship Program and service in the Corps, including a statement of all factors considered in approving applications for participation in the Program and in making assignments for participants in the Program.

* * * * * * *

(f) The written contract (referred to in this subpart) between the Secretary and an individual shall contain—

(1) an agreement that—

(A) * * *

(B) * * *

* * * * * * *

(iii) while enrolled in such course of study, to maintain an acceptable level of academic standing (as determined under regulations of the Secretary by the educational institution offering such course of study); [and]

(iv) if pursuing a degree from a school of medicine or osteopathic medicine, to complete a residency in a specialty that the Secretary determines is consistent with the needs of the Corps; and

[(iv)] *(v)* to serve for a time period (hereinafter in the subpart referred to as the "period of obligated service") equal to—

* * * * * * *

(3) a statement of the damages to which the United States is entitled, under section [338D] *338E* for the individual's breach of the contract; and

* * * * * * *

[(i) Not later than March 1 of each year, the Secretary shall submit to the Congress a report providing, with respect to the preceding fiscal year—

[(1) the number, and type of health profession training, of students receiving scholarships under the Scholarship Program;

[(2) the educational institutions at which such students are receiving their training;

[(3) the number of applications filed under this section in the school year beginning in such year and in prior school years;

[(4) the amount of scholarship payments made for each of tuition, stipends, and other expenses, in the aggregate and at

each educational institution for the school year beginning in such year and for prior school years;

[(5)(A) the number, and type of health professions training, of individuals who have breached the contract under subsection (f) through any of the actions specified in subsection (a) or (b) of section 338E; and

[(B) with respect to such individuals—

[(i) the educational institutions with respect to which payments have been made or were to be made under the contract;

[(ii) the amounts for which the individuals are liable to the United States under section 338E;

[(iii) the extent of payment by the individuals of such amounts; and

[(iv) if known, the basis for the decision of the individuals to breach the contract under subsection (f); and

[(6) the effectiveness of the Secretary in recruiting health professionals to participate in the Scholarship Program, and in encouraging and assisting such professionals with respect to providing primary health services to health professional shortage areas after the completion of the period of obligated service under such Program.]

SEC. 338B. NATIONAL HEALTH SERVICE CORPS LOAN REPAYMENT PROGRAM.

(a) ESTABLISHMENT.— * * *

(1) an adequate supply of physicians, dentists, *behavioral and mental health professionals,* certified nurse midwives, certified nurse practitioners, and physician assistants; and

(2) if needed by the Corps, and adequate supply of other health professionals [(including mental health professionals)].

(b) ELIGIBILITY.—To be eligible to participate in the Loan Repayment Program, an individual must—

(1)[(A) must have a degree in medicine, osteopathic medicine, dentistry, or other health profession, or be certified as a nurse midwife, nurse practitioner, or physician assistant;]*(A) have a degree in medicine, osteopathic medicine, dentistry, or another health profession, or an appropriate degree from a graduate program of behavior and mental health, or be certified as a nurse midwife, nurse practitioner, or physician assistant;*

* * * * * * *

(e) APPROVAL REQUIRED FOR PARTICIPATION.—

[(1) IN GENERAL.—]An individual becomes a participant in the Loan Repayment Program only upon the Secretary and the individual entering into a written contract described in subsection (f).

* * * * * * *

[(i) REPORTS.—Not later than March 1 of each year, the Secretary shall submit to the Congress a report providing, with respect to the preceding fiscal year—

[(1) the total amount of loan payments made under the Loan Repayment Program;

[(2) the number of applications filed under this section;

[(3) the number, and type of health profession training, of individuals receiving loan repayments under such Program;

[(4) the educational institution at which such individuals received their training;

[(5) the total amount of the indebtedness of such individuals for educational loans as of the date on which the individuals become participants in such Program;

[(6) the number of years of obligated service specified for such individuals in the initial contracts under subsection (f), and, in the case of individuals whose period of such service has been completed, the total number of years for which the individuals served in the Corps (including any extensions made for purposes of paragraph (2) of such subsection);

[(7)(A) the number, and type of health professions training, of such individuals who have breached the contract under subsection (f) through any of the actions specified in subsection (a) or (b) of section 338E; and

[(B) with respect to such individuals—

[(i) the educational institutions with respect to which payments have been made or were to be made under contract;

[(ii) the amounts for which the individuals are liable to the United States under section 338E;

[(iii) the extent of payment by the individuals of such amounts; and

[(iv) if known, the basis for the decision of the individuals to breach the contract under subsection (f); and

[(8) the effectiveness of the Secretary in recruiting health professionals to participate in the Loan Repayment Program, and in encouraging and assisting such professionals with respect to providing primary health services to health professional shortage areas after the completion of the period of obligated service under such Program.

OBLIGATED SERVICE

SEC. 338C. (a) * * *

(b)(1) If an individual is required under subsection (a) to provide service as specified in [section 338A(f)(1)(B)(iv)] *section 338A(f)(1)(B)(v)* or 338B(f)(1)(B)(iv) (hereinafter in this subsection referred to as "obligated service"), the Secretary shall, not later than ninety days before the date described in paragraph (5), determine if the individual shall provide such service—

* * * * * * *

[(5)(A) In the case of the Scholarship Program, with respect to an individual receiving a degree from a school of medicine, osteopathic medicine, dentistry, veterinary medicine, optometry, podiatry, or pharmacy, the date referred to in paragraphs (1) through (4) shall be the date on which the individual completes the training required for such degree, except that—

[(i) at the request of such an individual with whom the Secretary has entered into a contract under section 338A prior to October 1, 1985, the Secretary shall defer such date until the end of the period of time (not to exceed the number of years

specified in subparagraph (B) or such greater period as the Secretary, consistent with the needs of the Corps, may authorize) required for the individual to complete an internship, residency, or other advanced clinical training; and

[(ii) at the request of such an individual with whom the Secretary has entered into a contract under section 338A on or after October 1, 1985, the Secretary may defer such date in accordance with clause (i).

[(B)(i) In the case of the Scholarship Program, with respect to an individual receiving a degree from a school of medicine, osteopathic medicine, or dentistry, the number of years referred to in subparagraph (A)(i) shall be 3 years.

[(ii) In the case of the Scholarship Program, with respect to an individual receiving a degree from a school of veterinary medicine, optometry, podiatry, or pharmacy, the number of years referred to in subparagraph (A)(i) shall be 1 year.]

(5)(A) In the case of the Scholarship Program, the date referred to in paragraphs (1) through (4) shall be the date on which the individual completes the training required for the degree for which the individual receives the scholarship, except that—

(i) for an individual receiving such a degree after September 30, 2000, from a school of medicine or osteopathic medicine, such date shall be the date the individual completes a residency in a specialty that the Secretary determines is consistent with the needs of the Corps; and

(ii) at the request of an individual, the Secretary may, consistent with the needs of the Corps, defer such date until the end of a period of time required for the individual to complete advanced training (including an internship or residency).

[(C)] *(B)* No period of internship, residency, or other advanced clinical training shall be counted toward satisfying a period of obligated service under this subpart.

[(D) In the case of the Scholarship Program, with respect to an individual receiving a degree from an institution other than a school referred to in subparagraph (A), the date referred to in paragraphs (1) through (4) shall be the date on which the individual completes the academic training of the individual leading to such degree.]

[(E)] *(C)* In the case of the loan repayment program, if an individual is required to provide obligated service under such Program, the date referred to in paragraphs (1) through (4)—

(i) shall be the date determined under [subparagraph (A), (B), or (D)] *subparagraph (A)* in the case of an individual who is enrolled in the final year of a course of study;

* * * * * * *

[(e) Notwithstanding any other provision of this title, service of an individual under a National Research Service Award awarded under subparagraph (A) or (B) of section 472(a)(1)[1] shall be counted against the period of obligated service which the individual is required to perform under the Scholarship Program or under section 225 as in effect on September 30, 1977.]

PRIVATE PRACTICE

SEC. 338D. (a) * * *

[(b) The written agreement described in subsection (a) shall—

[(1) provide that during the period of private practice by an individual pursuant to the agreement—

[(A) any person who receives health services provided by the individual in connection with such practice will be charged for such services at the usual and customary rate prevailing in the area in which such services are provided, except that if such person is unable to pay such charge, such person shall be charged at a reduced rate or not charged any fee; and

[(B) the individual in providing health services in connection with such practice (i) shall not discriminate against any person on the basis of such person's ability to pay for such services or because payment for the health services provided to such person will be made under the insurance program established under part A or B of title XVIII of the Social Security Act or under a State plan for medical assistance approved under title XIX of such Act, and (ii) shall agree to accept an assignment under section 1842(b)(3)(B)(ii) of such Act for all services for which payment may be made under part B of title XVIII of such Act and enter into an appropriate agreement with the State agency which administers the State plan for medical assistance under title XIX of such Act to provide services to individuals entitled to medical assistance under the plan; and

[(2) contain such additional provisions as the Secretary may require to carry out the purposes of this section.

[For purposes of paragraph (1)(A), the Secretary shall by regulation prescribe the method for determining a person's ability to pay a charge for health services and the method of determining the amount (if any) to be charged such person based on such ability. The Secretary shall take such action as may be appropriate to ensure that the conditions of the written agreement prescribed by this subsection are adhered to.]

(b)(1) The written agreement described in subsection (a) shall—

(A) provide that, during the period of private practice by an individual pursuant to the agreement, the individual shall comply with the requirements of section 334 that apply to entities; and

(B) contain such additional provisions as the Secretary may require to carry out the objectives of this section.

(2) The Secretary shall take such action as may be appropriate to ensure that the conditions of the written agreement prescribed by this subsection are adhered to.

* * * * * * *

BREACH OF SCHOLARSHIP CONTRACT OR LOAN REPAYMENT CONTRACT

SEC. 338E. [254o] (a)(1) An individual who has entered into a written contract with the Secretary under section 338A and who—

(A) fails to maintain an acceptable level of academic standing in the educational institution in which he is enrolled (such level determined by the educational institution under regulations of the Secretary)[,]*;*

(B) is dismissed from such educational institution for disciplinary reasons[,]*; or*

(C) voluntarily terminates the training in such an educational institution for which he is provided a scholarship under such contract, before the completion of such training, [or]

[(D) fails to accept payment, or instructs the educational institution in which he is enrolled not to accept payment, in whole or in part, of a scholarship under such contract,]

in lieu of any service obligation arising under such contract, shall be liable to the United States for the amount which has been paid to him, or on his behalf, under the contract.

* * * * * * *

(b)(1)(A) Except as provided in paragraph (2), if (for any reason not specified in subsection (a) or section [338F(d)] *338G(d)* an individual breaches his written contract by failing [either] to begin such individual's service obligation under section 338A in accordance with section 338C or [338D or] *338D,* to complete such service obligation, *or to complete a required residency as specified in section 338A(f)(1)(B)(iv),* the United States shall be entitled to recover from the individual an amount determined in accordance with the formula

$$A=3\varphi(t-s/t)$$

in which "A" is the amount the United States is entitled to recover, "φ" is the sum of the amounts paid under this subpart to or on behalf of the individual and the interest on such amounts which would be payable if at the time the amounts were paid they were loans bearing interest at the maximum legal prevailing rate, as determined by the Treasurer of the United States; "t" is the total number of months in the individual's period of obligated service; and "s" is the number of months of such period served by him in accordance with section 338C or a written agreement under section 338D.

* * * * * * *

(3) The Secretary may terminate a contract with an individual under section 338A if, not later than 30 days before the end of the school year to which the contract pertains, the individual—

(A) submits a written request for such termination; and

(B) repays all amounts paid to, or on behalf of, the individual under section 338A(g).

* * * * * * *

(c)(1) If (for any reason not specified in subsection (a) or section [338F(d)] *338G(d))* an individual breaches the written contract of the individual under section 338B by failing either to begin such individual's service obligation in accordance with section 338C or 338D or to complete such service obligation, the United States shall

be entitled to recover from the individual an amount equal to the sum of—

[(A) in the case of a contract for a 2-year period of obligated service—

[(i) the total of the amounts paid by the United States under section 338B(g)(2) on behalf of the individual for any period of obligated service; and

[(ii) an amount equal to the unserved obligation penalty;

[(B) in the case of a contract for a period of obligated service of greater than 2 years, and the breach occurs before the end of the first 2 years of such period—

[(i) the total of the amounts paid by the United States under section 338B(g)(2) on behalf of the individual for any period of obligated service; and

[(ii) an amount equal to the unserved obligation penalty; and

[(C) in the case of a contract for a period of obligated service of greater than 2 years, and the breach occurs after the first 2 years of such period—

[(i) the total of the amounts paid by the United States under section 338B(g)(2) on behalf of the individual for any period of obligated service not served; and

[(ii) if the individual breaching the contract failed to give the Secretary notice, that the individual intends to take action which constitutes a breach of the contract, at least 1 year (or such shorter period of time as the Secretary determines is adequate for finding a replacement prior to the breach, $10,000.]

(A) the total of the amounts paid by the United States under section 338B(g) on behalf of the individual for any period of obligated service not served;

(B) an amount equal to the product of the number of months of obligated service that were not completed by the individual, multiplied by $7,500; and

(C) the interest on the amounts described in subparagraphs (A) and (B), at the maximum legal prevailing rate, as determined by the Treasurer of the United States, from the date of the breach.

[(2) For purposes of paragraph (1), the term "unserved obligation penalty" means the amount equal to the product of the number of months of obligated service that were not completed by an individual, multiplied by $1,000, except that in any case in which the individual fails to serve 1 year, the unserved obligation penalty shall be equal to the full period of obligated service multiplied by $1,000.

[(3) The Secretary may waive, in whole or in part, the rights of the United States to recover amounts under this section in any case of extreme hardship or other good cause shown, as determined by the Secretary.]

(2) The Secretary may terminate a contract with an individual under section 338B if, not later than 45 days before the end of the fiscal year in which the contract was entered into, the individual—

(A) submits a written request for such termination; and

(B) repays all amounts paid on behalf of the individual under section 338b(g).

[(4)] *(3)* Damages that the United States is entitled to recover shall be paid in accordance with subsection (b)(1)(B).

(d)(1) * * *

* * * * * * *

(3)(A) Any obligation of an individual under the Scholarship Program (or a contract thereunder) or the Loan Repayment Program (or a contract thereunder) for payment of damages may be released by a discharge in bankruptcy under title 11 of the United States Code [only if such discharge is granted after the expiration of the five year period] *only if such discharge is granted after the expiration of the 7-year period* beginning on the first date that payment of such damages is required, and only if the bankruptcy court finds that nondischarge of the obligation would be unconscionable.

* * * * * * *

(e) Notwithstanding any other provision of Federal or State law, there shall be no limitation on the period within which suit may be filed, a judgment may be enforced, or an action relating to an offset or garnishment, or other action, may be initiated or taken by the Secretary, the Attorney General, or the head of another Federal agency, as the case may be, for the repayment of the amount due from an individual under this section.

* * * * * * *

[SEC. 338H. REPORT AND AUTHORIZATION OF APPROPRIATIONS.

[(a) REPORT.—The secretary shall report on march 1 of each year to the Committee on Labor and Human Resources of the Senate, the Committee on Energy and Commerce of the House of Representatives, and the Committees on Appropriations of the Senate and the House of Representatives on—

[(1) the number of providers of health care who will be needed for the Corps during the 5 fiscal years beginning after the date the report is filed; and

[(2) the number—

[(A) of scholarships the Secretary proposes to provide under the Scholarship program during such 5 fiscal years;

[(B) of individuals for whom the Secretary proposes to make loan repayments under the Loan Repayment Program during such 5 fiscal years; and

[(C) of individuals who have no obligation under section 338C and who the Secretary proposes to have as members of the Corps during such 5 fiscal years,

in order to provide such number of health care providers.

[(b) FUNDING.—

[(1) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this subpart, there are authorized to be appropriated $63,900,000 for fiscal year 1991, and such sums as may be necessary for each of the fiscal years 1992 through 2000.

[(2) RESERVATION OF AMOUNTS.—

[(A) SCHOLARSHIPS FOR NEW PARTICIPANTS.—Of the amounts appropriated under paragraph (1) for a fiscal year, the Secretary shall obligate not less than 30 percent

for the purpose of providing contracts for scholarships under this subpart to individuals who have not previously received such scholarships.

[(B) SCHOLARSHIPS FOR FIRST-YEAR STUDY IN CERTAIN FIELDS.—With respect to certification as a nurse practitioner, nurse midwife, or physician assistant, the Secretary shall, of the amounts appropriated under paragraph (1) for a fiscal year, obligate not less than 10 percent for the purpose of providing contracts for scholarships under this subpart to individuals who are entering the first year of study in a course of study or program described in subsection 338A(b)(1)(B) that leads to such a certification. Amounts obligated under this subparagraph shall be in addition to amounts obligated under subparagraph (A).]

"SEC. 338H. AUTHORIZATION OF APPROPRIATIONS.

"(a) AUTHORIZATION OF APPROPRIATIONS.—For the purposes of carrying out this subpart, there are authorized to be appropriated $146,250,000 for fiscal year 2002, and such sums as may be necessary for each of fiscal years 2003 through 2006.

"(b) SCHOLARSHIPS FOR NEW PARTICIPANTS.—Of the amounts appropriated under subsection (a) for a fiscal year, the Secretary shall obligate not less than 30 percent for the purpose of providing contracts for scholarships under this subpart to individuals who have not previously received such scholarships.

"(c) SCHOLARSHIPS AND LOAN REPAYMENTS.—With respect to certification as a nurse practitioner, nurse midwife, or physician assistant, the Secretary shall, from amounts appropriated under subsection (a) for a fiscal year, obligate not less than a total of 10 percent for contracts for both scholarships under the Scholarship Program under section 338A and loan repayments under the Loan Repayment Program under section 338B to individuals who are entering the first year of a course of study or program described in section 338A(b)(1)(B) that leads to such a certification or individuals who are eligible for the loan repayment program as specified in section 338B(b) for a loan related to such certification.

SEC. 338I. GRANTS TO STATES FOR LOAN REPAYMENT PROGRAMS.

(a) IN GENERAL.—

[(1) AUTHORITY FOR GRANTS.—The Secretary, acting through the Administrator of the Health Resources and Services Administration, may make grants to States for the purpose of assisting the States in operating programs described in paragraph (2) in order to provide for the increased availability of primary health services in health professional shortage areas.]

(1) AUTHORITY FOR GRANTS.—The Secretary, acting through the Administrator of the Health Resources and Services Administration, may make grants to States for the purpose of assisting the States in operating programs described in paragraph (2) in order to provide for the increased availability of primary health care services in health professional shortage areas. The National Advisory Council established under section 337 shall advise the Administrator regarding the program under this section.

* * * * * * *

(e) REPORTS.—The Secretary may not make a grant under subsection (a) unless the State involved agrees—

[(1) to submit to the Secretary reports providing the same types of information regarding the program operated pursuant to such subsection as reports submitted pursuant to subsection (i) of section 338B provide regarding the Loan Repayment Program under such section; and]

(1) to submit to the Secretary such reports regarding the States loan repayment program, as are determined to be appropriate by the Secretary; and

* * * * * * *

(i) AUTHORIZATION OF APPROPRIATIONS.—

[(1) IN GENERAL.—For the purpose of making grants under subsection (a), there is authorized to be appropriated $10,000,000 for each of the fiscal years 1991 through 1995, and such sums as may be necessary for each of the fiscal years 1998 through 2002.]

(1) IN GENERAL.—For the purpose of making grants under subsection (a), there are authorized to be appropriated $12,000,000 for fiscal year 2002 and such sums as may be necessary for each of fiscal years 2003 through 2006.

* * * * * * *

[Section 338L is repealed.]

SEC. 338L. DEMONSTRATION PROJECT.

(a) PROGRAM AUTHORIZED.—The Secretary shall establish a demonstration project to provide for the participation of individuals who are chiropractic doctors or pharmacists in the Loan Repayment Program described in section 338B.

(b) PROCEDURE.—An individual that receives assistance under this section with regard to the program described in section 338B shall comply with all rules and requirements described in such section (other than subparagraphs (A) and (B) of section 338B(b)(1)) in order to receive assistance under this section.

(c) LIMITATIONS.—The demonstration project described in this section shall provide for the participation of individuals who shall provide services in rural and urban areas, and shall also provide for the participation of enough individuals to allow the Secretary to properly analyze the effectiveness of such project.

(d) DESIGNATIONS.—The demonstration project described in this section, and any providers who are selected to participate in such project, shall not be considered by the Secretary in the designation of a health professional shortage area under section 332 during fiscal years 2002 through 2004.

(e) RULE OF CONSTRUCTION.—This section shall not be construed to require any State to participate in the project described in this section.

(f) REPORT.—

(1) IN GENERAL.—The Secretary shall prepare and submit a report describing the information described in paragraph (2) to—

(A) the Committee on Health, Education, Labor, and Pensions of the Senate;

(B) the Subcommittee on Labor, Health and Human Services, and Education of the Committee on Appropriations of the Senate;

(C) the Committee on Energy and Commerce of the House of Representatives; and

(D) the Subcommittee on Labor, Health and Human Services, and Education of the Committee on Appropriations of the House of Representatives.

(2) CONTENT.—The report described in paragraph (1) shall detail—

(A) the manner in which the demonstration project described in this section has affected access to primary care services, patient satisfaction, quality of care, and health care services provided for traditionally underserved populations;

(B) how the participation of chiropractic doctors and pharmacists in the Loan Repayment Program might affect the designation of health professional shortage areas; and

(C) the feasibility of adding chiropractic doctors and pharmacists as permanent members of the National Health Service Corps.

(g) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, such sums as may be necessary for fiscal years 2002 through 2004.

* * * * * * *

SOCIAL SECURITY ACT

PAYMENTS OF BENEFITS

SEC. 1833. (a) * * *

* * * * * * *

(b) Before applying subsection (a) with respect to expenses incurred by an individual during any calendar year, the total amount of the expenses incurred by such individual during such year (which would, except for this subsection, constitute incurred expenses from which benefits payable under subsection (a) are determinable) shall be reduced by a deductible of $75 for calendar years before 1991 and $100 for 1991 and subsequent years; except that (1) such total amount shall not include expenses incurred for items and services described in section 1681(s)(10(A), (2) such deductible shall not apply with respect to home health services (other than a covered osteoporosis drug (as defined in section 1861(kk)), (3) such deductible shall not apply with respect to clinical diagnostic laboratory tests for which payment is made under this part (A) under subsection (a)(1)(D)(i) or (a)(2)(D)(i) on an assignment-related basis, or to a provider having an agreement under section 1866, or (B) the basis of a negotiated rate determined under subsection (h)(6), (4) [such deductible shall not apply to Federally qualified health center services.] *such deductible shall not apply to rural health clinic services made available through a rural health clinic to which members of the National Health Service Corps are assigned under section 333 of the Public Health Service Act, provided to an individual who qualifies for subsidized services under the Public Health*

Service Act or Federally qualified health center services. The total amount of the expenses incurred by an individual as determined under the preceding sentence shall, after the reduction specified in such sentence, be further reduced by an amount equal to the expenses incurred for the first three pints of whole blood (or equivalent quantities of packed red blood cells, ad defined under regulations) furnished to the individual during the calendar year, except that such deductible for such blood shall in accordance with regulations be appropriately reduced to the extent that there has been a replacement of such blood (or equivalent quantities of packed red blood cells, as so defined); and for such purposes blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual shall be deemed replaced when the institution or other person furnishing such blood (or such equivalent quantities of packed red blood cells, as so defined) is given one pint of blood for each pint of blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual with respect to which a deduction is made under this sentence. The deductible under the previous sentence for blood or blood cells furnished an individual in a year shall be reduced to the extent that a deductible has been imposed under section 1813(a)(2) to blood or blood cells furnished the individual in the year, (5) such deductible shall not apply with respect to screening mammography (as described in section 1861(jj)), and (6) such deductible shall not apply with respect to screening pap smear and screening pelvic exam (as described invsection 1861(nn)).

* * * * * * *

○